Health Sciences & Human Services Library
University of Maryland
Baltimore

NOT TO CIRCULATE

Health Sciences & Human Services Library
University of Maryland
Baltimore

NOT TO CIRCULATE

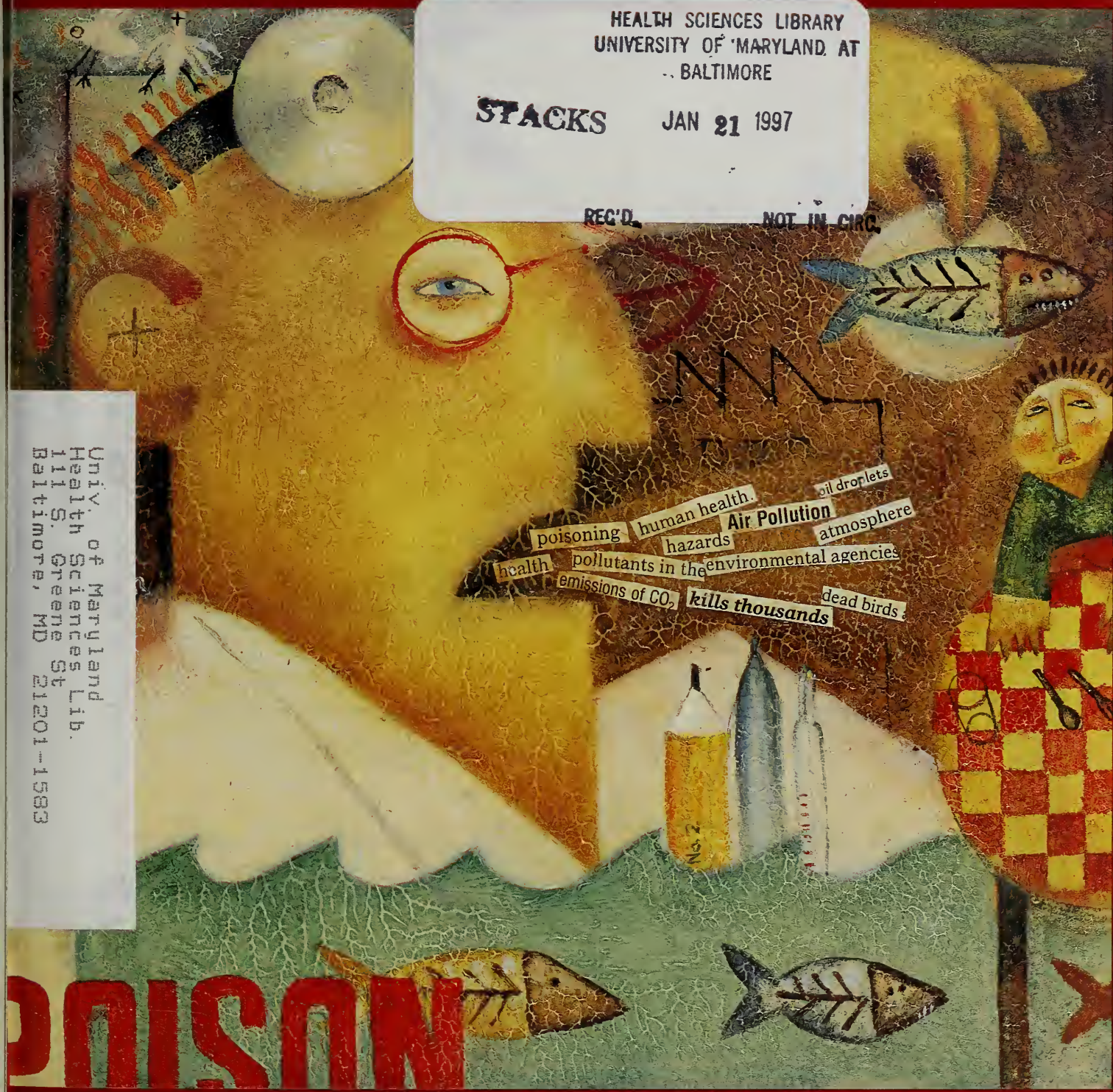
Digitized by the Internet Archive
in 2016

https://archive.org/details/minnesotamedicin8011minn

Minnesota Medicine

A JOURNAL OF CLINICAL AND HEALTH AFFAIRS

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE
STACKS JAN 21 1997
REC'D NOT IN CIRC.



Univ. of Maryland
Health Sciences Lib.
111 S. Greene St
Baltimore, MD 21201-1583

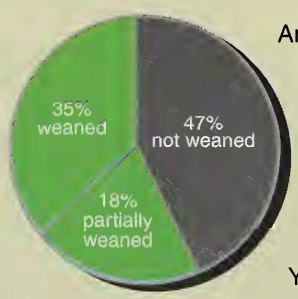
UNRAVELING THE MYSTERIES OF
ENVIRONMENTAL MEDICINE

JANUARY 1997



More than 1/2 of our respiratory patients are freed from ventilator dependency.

We specialize in weaning the "unweanable." With aggressive therapies, dedicated staff, and advanced techniques, our Prolonged Respiratory Care Unit (PRCU) has successfully treated the nation's most difficult respiratory cases.



And we have helped 47% of our respiratory patients go home or to home care with most cases discharged in under 28 days.

So when you need respiratory care experts you can count on, call us.

You've got our number.

Call for your free outcome report

HealthEast Bethesda Lutheran Hospital & Rehabilitation Center

559 Capitol Boulevard St. Paul, MN 55103

1-800-566-2720

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Elizabeth Lada.

DEPARTMENTS

2 ..... Editor's Notebook

6 ..... Letters to the Editor

22 .... Author Instructions

52 .... News Clips

58 .... CME in Minnesota

60 .... Classified Ads

64 .... Index to Advertisers

FACE TO FACE

8 **Going to Extremes** ..... Miriam K. Feldman
As chief medical officer for the worst nuclear catastrophe in history, Victor Koscheyev, M.D., discovered how little we really know about managing large-scale disasters.

COVER STORY

12 **Unraveling the Mysteries of Environmental Medicine** ..... Michael P. Moore
Medical 'detectives' try to reconcile research findings with often stubborn public perception.

CLINICAL & HEALTH AFFAIRS

23 **Rescue Worker and Population Protection in Large-Scale Contamination Disasters** ..... Victor S. Koscheyev, M.D., Ph.D., Sc.D., and Gloria R. Leon, Ph.D.

SPECIAL REPORT

29 **Conducting Truck Drivers' Physical Exams: The High Prevalence of Sleep Apnea** ..... Donald S. Asp, M.D.
Comprehensive physical exams are of utmost importance given truck drivers' risk for sleep apnea and other sleep-related breathing problems.

EDITORIAL

42 **Do State Licensing Procedures Discriminate Against Physicians Using Mental Health Services?** ..... Steven Miles, M.D.
One physician calls for reform.

MEDICINE LAW & POLICY

47 **The Impact of the Americans with Disabilities Act on Medical Licensing and Credentialing** ..... Margo S. Struthers, J.D., and Melissa Raphan, J.D.
Recognizing its obligations under the ADA, the BMP has modified licensing application questions, and entities credentialing physicians may similarly analyze their questions.

BOOK REVIEW

50 **An Environmental Thriller** ..... Charles R. Meyer, M.D.
"Our Stolen Future" forecasts deformed offspring and mass sterility, but does the warning have scientific foundation?

33 The Monitor

Highlights ..... *MMA goals for 1997 legislative session • Highlights of AMA interim meeting • Viewpoint: "It's time to replace the 2 percent tax"*

Diagnosing Environmental Disasters



"Natural and human disasters upset the tidy rules and procedures of medicine."

Physicians are like Dean Witter. You know the ad. A vested, wire-rimmed scion of the brokerage firm peers out of a black-and-white facsimile of a newsreel and intones, "We build success one investor at a time." Substitute "patient" for "investor" and you have the kernel of the motto practicing physicians carry with them each day. Yet a Dean Witter strategy in medicine entails a liability. If physicians focus only on the micro-environment of the patient, they may miss the pathogenic macroenvironment that surrounds the patient. Poverty and domestic violence may disable our patients more than viruses. Natural and human disasters upset the tidy rules and procedures of medicine. This month's *Minnesota Medicine* examines two macro health threats—disasters and the environment—and speculates how they might enter our exam rooms.

Our cover story (page 12) surveys the world of environmental medicine. Environmental threats are also covered in the clinical article on large-scale disasters (page 23) and the book review of "Our Stolen Future" (page 50). Our profile (page 8) features Dr. Victor Koscheyev, chief medical officer during clean-up of the nuclear power plant explosion at Chernobyl.

It's hard for Minnesotans to think in disaster terms. The likelihood that Minnesota docs will ever experience a Chernobyl seems remote. Yet, as I write this, the morning paper tells of a chlorine leak in Minneapolis that resulted in evacuations, rerouted traffic, and alerting Hennepin County Medical Center's emergency department. Even if we don't experience a disaster, we may meet patients who have. I have seen Russian immigrants in my office who lived near Chernobyl and worry about their exposure. The fear on their faces makes disaster real.

It's equally hard to think about environmental threats. Like radioactivity and parts-per-trillion contaminants, they're invisible. Like the aging of those we live with, they occur imperceptibly. Like most diseases, proof of their danger comes incrementally.

Physicians learn a mass of established knowledge and then spend a career applying it to patients who walk through the door. Each patient's disease is a puzzle to be solved using the rituals of history, physical, and tests. With the messiness of multiple diseases and the human psyche, this puzzle-solving can be daunting. It's hard enough keeping up with microbes and metastases; why do we have to consider toxins, terrorists, and turmoil? I offer two reasons:

- Understanding big systems has become a necessity for practicing medicine. Whether a million-dollar hospital corporation, a billion-dollar HMO, or a trillion-dollar government, huge organizations manipulate our careers and personal lives. Large organizations created most of the disaster and environmental problems detailed in our cover and clinical articles. Paradoxically, the solutions to megaproblems like Chernobyl or Oklahoma City require immense cooperative efforts. The more we know the anatomy, physiology, and pathology of big organizations, the more we can contribute to the solution.
- Etiology is at the heart of medicine. Classic etiologies like infection, inflammation, and autoimmunity may not start the disease causation cascade. Environmental toxins can predispose a person to infection, trigger inflammatory responses, or alter human immunity. Just looking at the blood culture, the sed rate, or the antinuclear antibody may prove to be a shallow analysis of what leads to disease.

Good brokers need to know how to analyze a company. But they also should know the CPIs and GNPs of macroeconomics. Physicians need to know the micro and the macro, diagnose the patient and the patient's world, and treat the individual but also understand the environment and what it can do to us.

–Charles R. Meyer, M.D., Editor-in-Chief

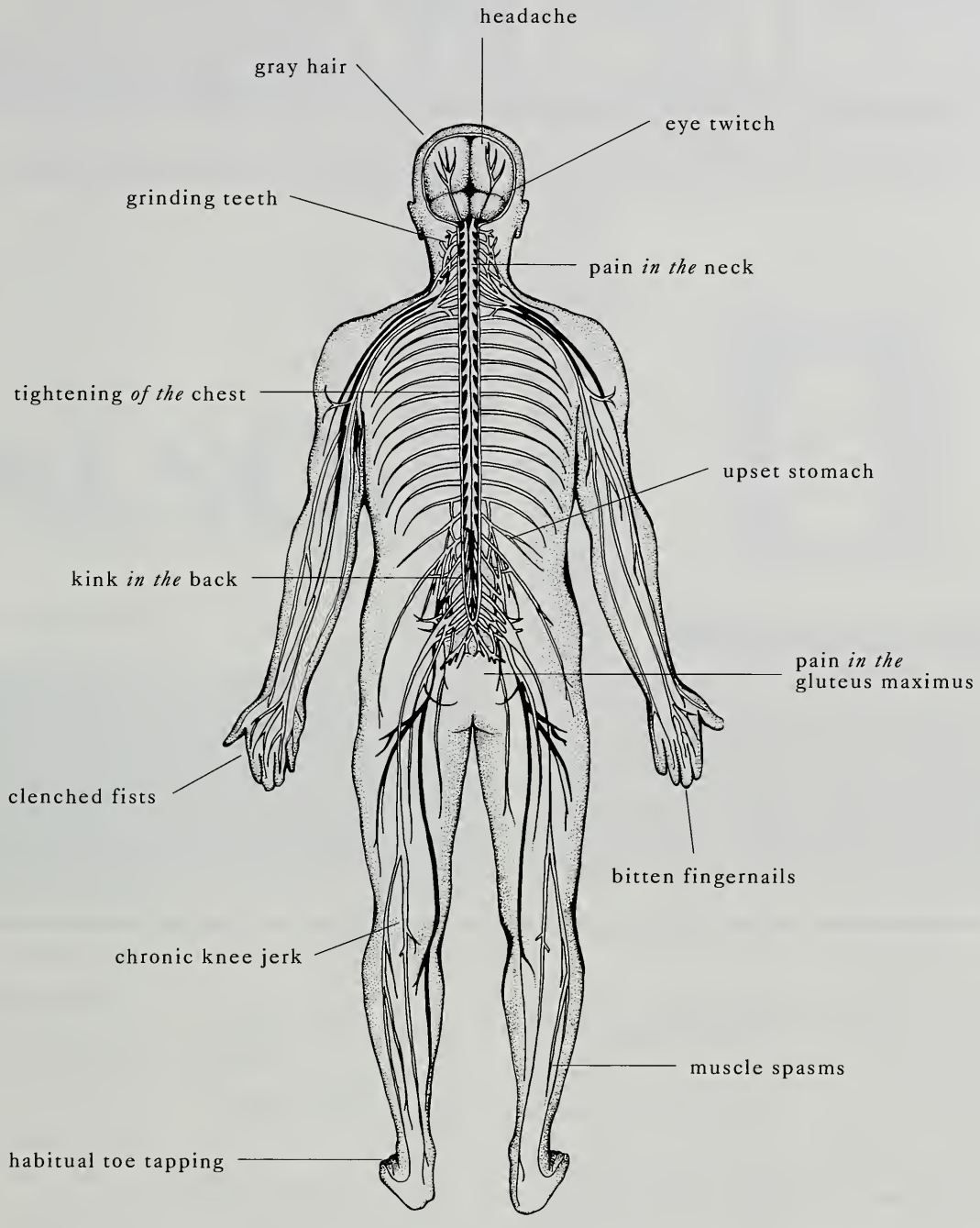


Figure 23

THE SIDE EFFECTS *of* DEALING WITH INSURANCE CLAIMS

U S WEST® CLAIMS DIRECT *and* U S WEST STATEMENTS DIRECT

Introducing a new cure for your insurance claim afflictions. With these services, all claims are processed electronically. Patient statements are then printed and mailed directly by U S WEST. Lowering office expenses and saving staff time. It's a total solution that works with all existing computer systems and software. No complicated staff training is required. And signing up is so easy, it won't hurt one bit. So give us a call. And watch your symptoms disappear, one by one.

USWEST®
1-800-654-2180

You may select from solution components independently or as a complete solution. Available to health care providers only. ©1996 U S WEST® Communications, Inc.

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor and Graphic Designer
Susan Rodsjo

Consulting Editor
Lenore Franzen

Publications Assistant
Juliet Ramotar

Graphic Designer
Michael May

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1996-97 Officers

President
Raymond G. Christensen, M.D.

President-Elect
Kent S. Wilson, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Paul R. Hamann, M.D.

Secretary
Judith F. Shank, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Anthony C. Jaspers, M.D.

Vice Speaker of the House
Blanton Bessinger, M.D.

Past President
Michael J. Murray, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Trinky Pollard

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth Crabb, M.D.
Theodore L. Fritsche, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875.

E-mail: mma@mnmed.org

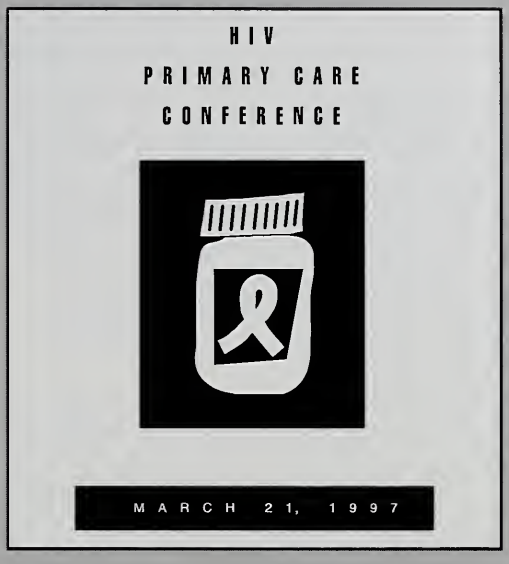
Web site: www.mnmed.org

Continuing Medical Education

Hennepin County Medical Center Activities



Advanced Life Support in Obstetrics (ALSO)
February 21-22
Hennepin County Medical Center, Minneapolis
15.0 Credit Hours



Primary Care of HIV
March 21
Co-sponsored with Allina Health Systems
The Metropolitan Conference Center, Minneapolis
7.0 Credit Hours

Osteoporosis Conference
March 7
Doubletree Grand Hotel, Bloomington
Approx. 6.0 Credit Hours

Research Statistics
March 13-14 and April 17-18
Hennepin County Medical Center, Minneapolis
Approx. 12.0 Credit Hours

Exploring Biomedical Ethics
April 11
Hennepin County Medical Center, Minneapolis
Approx. 6.0 Credit Hours

Through The Eyes of Others:
Envisioning Culturally Competent Health Care
May 2-3
Earle Brown Heritage Center, Brooklyn Center
Approx. 12.0 Credit Hours

Annual John I. Coe Symposium/MSP Meeting
(Pathology-related, focus this year on infectious disease)
May 16-17
St. Cloud Civic Center, St. Cloud
Approx. 6.5 Credit Hours

Infection Control
Infection Control lectures, required by the MN Medical Practice Board for physicians, are offered on a continuing basis throughout the year. These lectures are held in the HCMC Pillsbury Auditorium over the Noon-hour. Please contact our office for further information.

Hennepin County Medical Center
HCMC
Level 1 Trauma Center

For further information or registration materials please contact:
HCMC Continuing Medical Education • 701 Park Ave.,
Mail Code 869-A • Minneapolis, MN 55415 • (612) 347-2075,
Fax (612) 904-4210, Toll free 888-263-4262 (CME@HCMC)



Tips for Improving the MMA's Home Page

I am thrilled to see that the Minnesota Medical Association has finally created a Web site, as described in the November issue of *Minnesota Medicine*. I also commend you on the great look and feel of the issue (I loved the www-esque cover!).

The picture of your home page looks very neat and inviting, but does the MMA know how many of us Net users have the ability to access frames? I can use the Internet from home or office and average 50 hours of on-line time per month, but I cannot view your home page because I can't use frames yet. I will be sure to upgrade to Netscape Navigator 3.0, but I thought you should know that many potential mnmed.org users are probably frustrated because they cannot view your material. Perhaps you might consider an easy way for the slow-to-upgrade types like me to view your home page via your Web site.

Also, do you know that the November *Minnesota Medicine* included only one tiny mention of the MMA's E-mail address? Since I cannot access the return E-mail function of your Web site, I was lucky to find the tiny mention. I share these points with you as an ally and friend of the MMA.

In St. Cloud, we have started the Medical Computer Club of St. Cloud, of which I am secretary and Greg Meyers, M.D., is president. We are urging our computer-reluctant peers to get up and running on computers. Please visit our emerging Web site at http://www.mccsc.org

Pat Zook, M.D.
Family Physician
St. Cloud, Minnesota

Thank You for Sharing Comments on the MMA's Web Site

We appreciate the many comments we've received from our members since the unveiling of the MMA Web site, www.mnmed.org

Like Dr. Zook, several members told us about the technical difficulties they experienced when attempting to connect to the site using their older versions of Internet software. The many different types and versions of software available made it difficult for us to decide which one to use for the MMA site.

We adopted the rule of always supporting one generation of earlier software in addition to the current versions. Members running current Web browsers (Netscape Navigator 3.0 and Internet Explorer 3.0) and those using the prior versions of each program (Netscape Navigator 2.2 and Internet Explorer 2.0) will have no difficulty accessing our site. If your software is two or more generations out of date, however, you will need to upgrade.

An upgrade is necessary because of the "frames" to which Dr. Zook refers. On the MMA site, the frame is contained in the navigation guide, which remains on the left side of the page no matter where you go on the site. This constant reference point dramatically eases the usability of the site but does not function with outdated software.

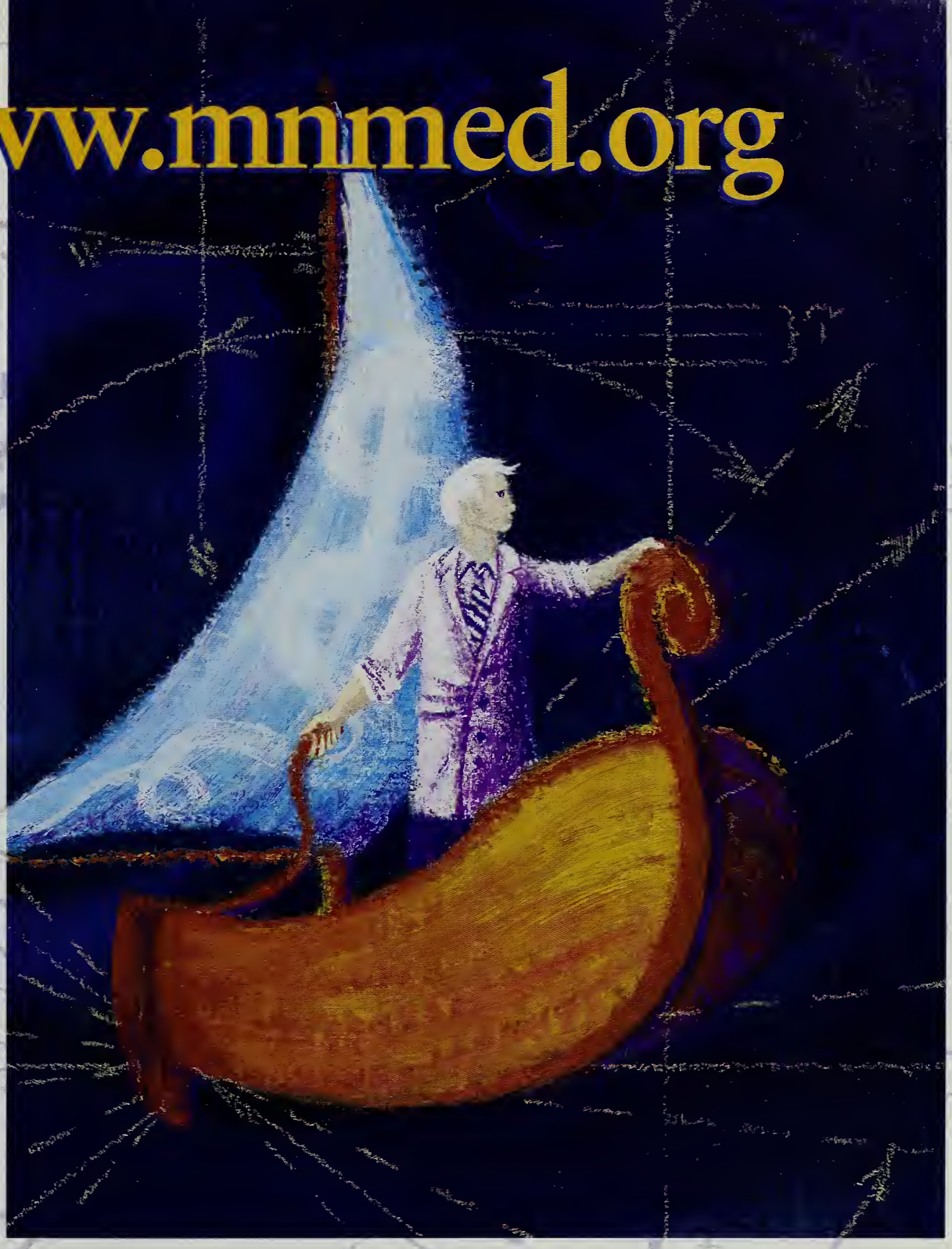
The Microsoft browser is free at www.microsoft.com. Netscape (www.netscape.com) provides individuals, businesses, and government organizations free evaluation copies of Netscape Navigator for up to 90 days. Students, faculty, and staff members of educational institutions and employees of charitable nonprofit organizations may use Netscape Navigator free of charge.

Finally, as Dr. Zook points out, it is essential to "get the word out" about the MMA's presence on the Internet. Our Web site and E-mail addresses are now on our association's letterheads and business cards and are published in *Minnesota Medicine* on page 4.

Please continue to visit the MMA Web site at www.mnmed.org, and E-mail your comments about the Web site or any other concern to mma@mnmed.org

Steve Dombrosk, Director
Management Information Services
Minnesota Medical Association

www.mnmed.org



The Minnesota Medical Association ventured into cyberspace September 18 with the unveiling of its World Wide Web home page. In doing so, the MMA established a presence among the several hundred million people who use the Internet.

The MMA home page provides physicians a "port of entry" into cyberspace. We want our home page to be the *first* place Minnesota physicians go when exploring the Web. Physicians will no doubt move beyond our home page, but we encourage them to begin their on-line time at the MMA site.

The Internet, unlike publishing and television, is a two-way medium. The MMA Web site contains more than 100 points where members are able to communicate with us. Our site has many links that will allow you to send E-mail to MMA committees and staff. Please make use of these links to share your thoughts with us!

The best way to explore any Web site, MMA's included, is to visit the site with your computer. Visit our home page at *www.mnmed.org*

MMA
MINNESOTA MEDICAL ASSOCIATION
MEDICINE'S VOICE IN MINNESOTA

Going to Extre

As chief medical officer for the worst nuclear catastrophe in history, Victor Koscheyev, M.D., discovered how little we really know about managing large-scale disasters.

By Miriam K. Feldman

Victor S. Koscheyev, M.D., says he is not brave. Yet in May 1986, he traveled from Moscow to Chernobyl, where a nuclear reactor had recently exploded, spewing 200 times more radioactive poison into the air than had been released at Hiroshima and Nagasaki. Koscheyev had been appointed chief medical officer for what's considered the worst civilian disaster in the history of nuclear energy.

Koscheyev knew the risks of exposure, but years of working on matters related to nuclear power stations and weapons had inured him to fear. Besides, he wore a mask and protective clothing. "I understood what dosage level would affect the human body," said Koscheyev in a recent interview from his office at the University of Minnesota. "I'm not brave."

At the time of the explosion, Koscheyev was head of the Department of Human Performance in Extreme and Disaster Environments at the Institute of Biophysics and Specialized Center for Disaster Medicine "Protection" in Moscow. The position drew on his skills as a medical doctor and as a scientist trained in disaster medicine. An expert on large-scale disasters, Koscheyev was clearly the right person to lead clean-up efforts at Chernobyl.

Yet a different sort of disaster—the collapse of the Russian economy—put Koscheyev on a trajectory from Moscow to Minnesota. The turmoil that Perestroika caused resulted in a "brain drain," in which many scientists left the country after losing their financial support. "I came to the United States to develop funding for collaborative scientific research with institutes in Russia," he says.

nes



PHOTOGRAPH BY BRUCE BAIRD

Minnesota was a logical new home for Koscheyev, not just because he is a native of Siberia and no stranger to the cold. When he arrived at the University of Minnesota in January 1993 as a National Research Council (NRC) senior research fellow, he already had strong ties to the state. He had collaborated on explorer Paul Schurke's 1989 U.S.-Soviet Bering Bridge Expedition and had worked on the Russian translation and standardization of the Minnesota Multiphasic Personality Inventory (MMPI) psychological test.

One thing led to another, and Koscheyev's NRC fellowship evolved into a senior fellow position at the university's Division of Environmental and Occupational Health (EOH) in the School of Public Health. Today he is senior fellow in the School of Kinesiology and Leisure Studies, where he plans to continue his research on disasters and extreme conditions.

Lucky for Minnesota. In an interview last year with the *St. Paul Pioneer Press*, Ian Greaves, M.D., associate professor, EOH, noted that Koscheyev had created a research institution in Moscow unequaled in the world. "The breadth of his knowledge is incredible," Greaves told the *Pioneer Press*. In 1993, the U.S. Immigration and Naturalization Service granted Koscheyev permanent resident status under the classification of "scientist of extraordinary ability."

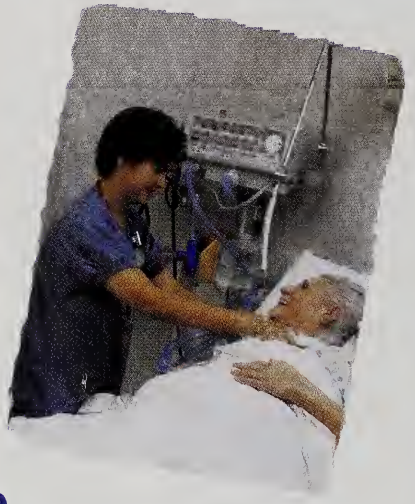
Koscheyev's expertise ranges from designing space suits to managing nuclear disasters to preparing for cold-weather expeditions. While these scientific pursuits may at first glance seem unrelated, they all pertain to the effect of extreme environmental conditions—natural or man-made—on humans. Koscheyev has made a career of studying the limits of human endurance.

Now, 10 years after Chernobyl, Koscheyev, 57, works out of a large but sparsely furnished office. His desk holds the normal clutter of papers, along with a Russian/English dictionary. Posters depict the earth in orbit and an astronaut dressed in a suit Koscheyev designed. On the bookshelf is a protective mask and volumes in Russian and English—hardly best-sellers, but titles reflecting his interest in environmental health, abnormal psychology, personal and industrial safety, and treatment of radiation injuries. Copies of a few of the nearly 300 articles he's written lie on a work table. Koscheyev is also author of eight books on the protection of people under extreme environmental conditions.

If all goes according to plan, Koscheyev's office may become the hub of a new Health Protection Center (see related article, page 23). "It's my dream," he says, his arms and hands constantly in motion as he speaks, "to study ways to provide health protection for people in different extreme environments." He also speaks of teaching disaster management, a need that Chernobyl made all too clear. "I would like to join different scientists and medical and engineering people to create new technologies for large-scale disasters."

Koscheyev discovered how little we know about handling these disasters from his experience at Cher-

SPECIAL CARE
FOR SPECIAL PATIENTS



Recovery from an illness, accident or injury requires experienced medical professionals, state of the art equipment and technologically advanced therapies. It also requires a comforting, nurturing staff, a "home away from home" environment and family involvement in patient care. Our hospital is dedicated to the recovery of critically ill patients. And we're with you every step of the way, with cost effective care that includes:

- *Pulmonary/Ventilator Program*
- *Wound Care Program*
- *Medically Complex Program*
- *Low Tolerance Rehabilitation Services*
- *Early Cognitive Recovery Program*

THC · Minneapolis...dedicated to returning each patient to the most productive life possible.

THC
Minneapolis
A Subsidiary of Transitional Hospitals Corporation
621-588-2750

nobyl. All the talk, all the preparation for such a situation, was merely academic. It did little to equip the Soviets for what actually happened. "A real large-scale disaster is much different from our imagination and from our prediction," he says. "Nobody has enough experience in large-scale disasters."

Koscheyev speaks of the difficulties he encountered at Chernobyl while managing armies of rescue workers and triaging victims. "Thousands of people had to be moved, but thousands had to come to the area for cleaning and repair," he says. Local medical facilities couldn't be used because they were contaminated. And everything, from people to rescue trucks, had to be decontaminated before they were moved to safety zones in the provinces, Kiev, and Moscow.

Although the Health Protection Center that Koscheyev envisions cannot provide direct experience such as he has, it could be a place to plan for what he believes is the inevitable next disaster, nuclear or otherwise. "A disaster is any catastrophe for society that has huge consequences," Koscheyev explains. Chernobyl was one kind. The bombing of the Alfred P. Murrah Federal Building in Oklahoma City was another.

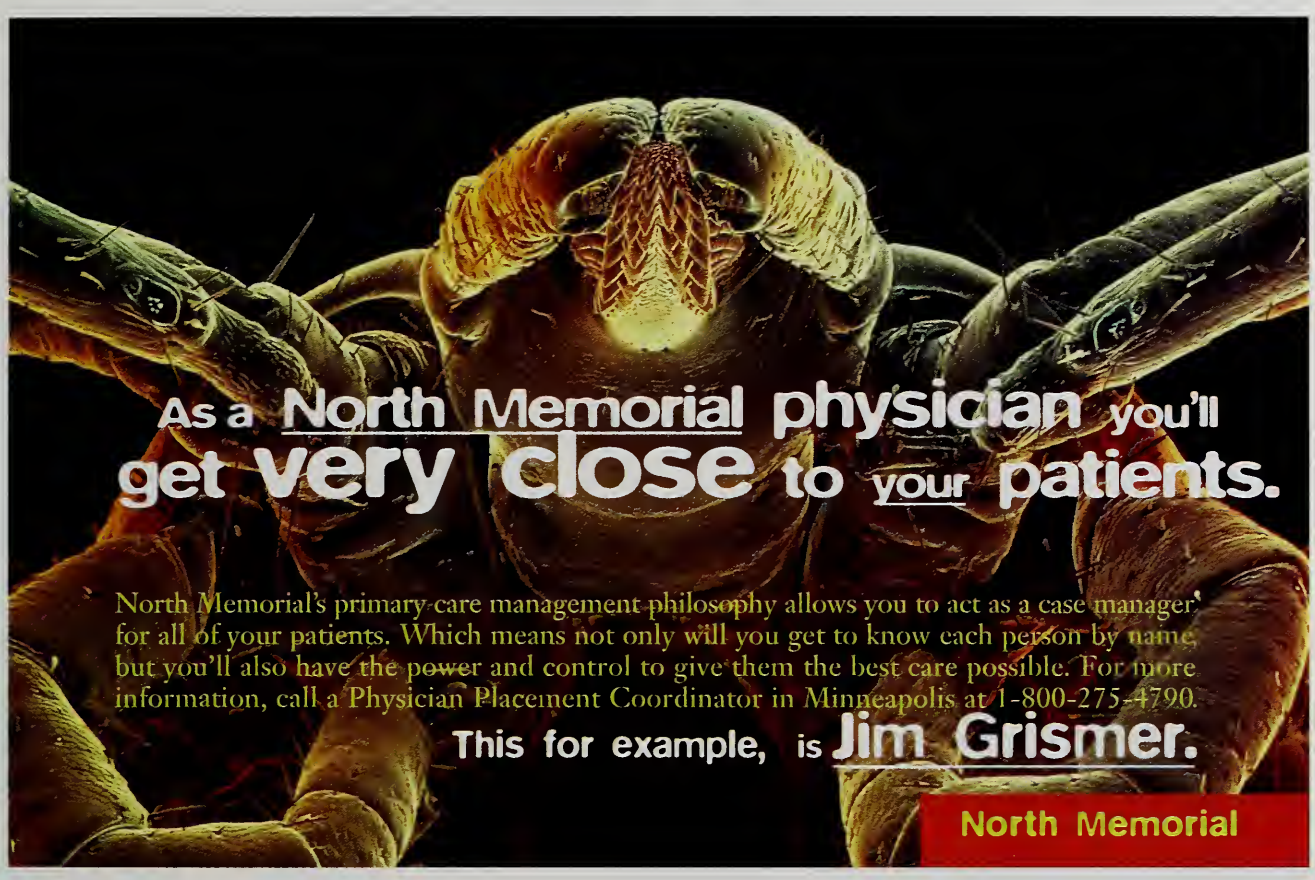
Plans for the center are moving at a frustrating pace, in part because government officials are having difficulty perceiving how the mission of their specific agency fits into the concept of a center focused on health protection in large-scale disasters. Nevertheless, Koscheyev has kept busy with other protection activities. He received NASA funding for a three-year project devoted to providing better comfort and protective conditions for astronauts who must work in the harsh environment outside of the spaceship while constructing the international space station. Again, Koscheyev is the right person for the task. In his earliest research, he designed protective suits for workers in cold conditions and antimicrobial clothing to combat the exchange of germs in a small space.

Koscheyev also has some down-to-earth projects in mind, inspired by Minnesota's extreme climate. "When I arrived in Minnesota, I met Siberia again," he recalls, noting that Minnesota actually seems colder; he calls it Siberia with a wind chill. Koscheyev is seeking support to develop devices to protect fingers, toes, and faces from the sharp wind. He is currently discussing these projects with related industries.

Koscheyev's efforts to make us all a bit more comfortable still leave him time to worry about our safety. He is particularly concerned by the world's aging nuclear power plants and weapons stockpile. He worries about instability in the former Soviet Union, about the Middle East's pursuit of atomic weapons, and the growth of a black market for nuclear materials. And nationalist flare-ups at home leave him wondering who might push the button in the current unstable political climate.

"Each country must constantly pay attention to facilities and situations that are dangerous," warns Koscheyev. "It's important that we not be asleep." MM

Miriam K. Feldman is a free-lance writer in Minneapolis and a frequent contributor to Minnesota Medicine.



HealthPartners
St. Paul-Ramsey Medical Center

CME
640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

CONTINUING MEDICAL EDUCATION
1997 WINTER/SPRING CONFERENCE SCHEDULE

Burn Care Today	Feb. 20-21
Family Medicine Today	March 20-21
Annual Occupational Medicine Update	March 21
Annual Obstetrics & Gynecology Update	April 3-4
Annual ENT Update	April 4
Critical Care 1997	April 17-18
NIOSH-Approved Spirometry	April 30-May 1
Agricultural Medicine	TBA

INFORMATION AND REGISTRATION:
Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612-221-3992 • Fax 612-292-4773

St. Paul-Ramsey Medical Center/Ramsey Clinic/Ramsey Foundation are Members of the HealthPartners Family of Health Care Organizations

HealthPartners
RAMSEY



ILLUSTRATION BY ELIZABETH LADA

UNRAVELING THE MYSTERIES OF ENVIRONMENTAL MEDICINE




The headlines shout the bad and good news:

"Aspartame Linked to Brain Tumors"
"Panel Finds EMFs Pose No Threat"
"Fish Hormone Problems Linked to Toxins"
"War on Cancer Pays Off"

These headlines, from just one week's sampling of major newspapers, illustrate the range of environmental health issues we face and the roller coaster ride of emotions these issues evoke. Each headline contradicts previous reports on the subject, and before long, another study is bound to do the same.

Despite, or perhaps because of, the lack of clear answers, concern about the environment and its impact on health is high on the public's and media's agenda. People aren't sure what to believe and wonder how they can protect themselves and their families from chemical threats.

Many people, including physicians, turn to the Minnesota Department of Health for answers. They're likely to talk with Allan Bender, D.V.M., Ph.D., section chief for Chronic Disease and Environmental Epidemiology. "When scientists speak of the 'environment,'" says Bender, "they are speaking of *all* the things in an individual's environment that can impact health: diet, smoking, alcohol, stress, everything extrinsic to genetics." The media, adopting this broad understanding of 'environment,' may communicate that environmental factors are responsible for most cancers. The public applies its own definition of environment and concludes that air and water contaminants are to blame.

Another resource on environmental medicine is John Soler, M.P.H., chronic disease epidemiologist at the Health Department. "I get a fair number of calls from patients whose physicians think their cancer may be due to an environmental contaminant," Soler says. "While one can't say yes or no to that particular individual, the perception is that many of the cancers in our community are caused by environmental pollution." Despite that perception, there's a notable lack of research linking cancer with environmental contaminants or pollutants, unless, Soler says, "there are situations in occupations or other clear exposures."

A Growing Field

As self-described "noninfectious disease" epidemiologists, Bender and Soler represent the most prevalent and fastest growing type of environmental health professional. Working in the public health departments of government and universities, they and their colleagues gather and analyze morbidity and mortality data, searching for trends of importance to public health and policymaking. Based on that research as well as their experience investigating potential problems, they advise other health professionals, policymakers, the media, and the public on environmental health issues as diverse as radon gas in homes, "sick-

BY MICHAEL P. MOORE

building" syndrome, water quality, and air pollution.

Of growing interest to some epidemiologists is how environmental risks are communicated and policy decisions made. That is the focus of the Center for Environmental and Health Policy at the University of Minnesota School of Public Health. Its goals include serving as a link between scientists and policymakers to improve environmental decision-making. Center director Ken Sexton, Sc.D., says that despite the general consensus that we need to make better environmental decisions, there has been relatively little study of how science factors into public perceptions and governmental regulations. The center aims to fill that gap and to train future leaders in environmental health policy.

The center's deputy director, Ian Greaves, M.D., is a former internist who became intrigued by the complex puzzles of environmental health. Greaves says that despite the exploding interest in this field of research, there are few physicians on the front line of environmental medicine trained to evaluate patients with possible exposures to environmental toxins. Only about 2,000 physicians practice environmental and occupational medicine in the United States, says Greaves. Most are in private industry, focusing on the worksite as a specific environment in which occupational hazards must be identified and addressed. Smaller numbers of physicians practice environmental and occupational medicine in large clinics, hospitals, state and federal agencies, and academia. There are 120 Minnesota members of the American College of Environmental and Occupational Medicine, and about one-third are certified, with all but two of those practicing in the Twin Cities.

THE PRIMARY PHYSICIAN'S ROLE

Primary care physicians need to consider the possibility of environmental exposures when making a diagnosis, and they need to know when to refer the patient for toxicology or other screening, says Robert Orford, M.D., an occupational and environmental medicine specialist at Mayo Clinic in Scottsdale, Arizona.

One resource for physicians is "Environmental Issues in Primary Care," a booklet developed for the Minnesota Department of Health by the Freshwater Foundation's Health & Environment Digest. Orford says the booklet has been extremely useful for training primary care physicians and other health professionals.

The booklet's introduction describes a 1990 National Academy of Science committee report titled "Role of the Primary Care Physician in Occupational and Environmental Medicine." The Committee recommended that physicians improve their ability to identify conditions caused by environmental contaminants, to obtain histories that include environmental risk conditions, and to make appropriate diagnoses and referrals.

The rural physician training program at the University of Minnesota–Duluth School of Medicine is preparing students for this role. "The course brings to their attention the possibility of environmental factors in a diagnosis," says Kendall Wallace, Ph.D., a toxicologist and associate professor of biochemistry and molecular biology. Wallace, along with a pathologist, an emergency physician, and an occupational medicine specialist, presents students with case histories that they must solve by requesting appropriate tests and gathering further information. "Most of the cases are pathological, but we throw in the most likely toxin exposures they might encounter in a rural environment," Wallace says. "They work in teams and then present their diagnosis. I think they come away with a new awareness of toxic exposures that can mimic other disorders."

Wallace emphasizes the primary physician's critical role. "You have to be ready for anything, attuned to the possibility that symptoms might be environmentally related, and then know where the resources are to help make the diagnosis and treat the patient." *–MPM*

Environmental Medicine Resources

Following are two resources available to help physicians better understand environmental medicine:

- Murdock BS. Environmental issues in primary care. Minneapolis: Minnesota Department of Health, 1991.

- Sexton K, Murdock BS, eds. Environmental policy in transition: making the right choices. In: The Minnesota series in environmental decision making. Vol. 1. Minneapolis: Center for Environment and Health Policy, School of Public Health, University of Minnesota, 1996.

Environmental Epidemiology: The Health Department's Cancer Watch

As with most state health departments, the Minnesota Department of Health has a watchdog role in environmental health. Bender's job is to monitor the incidence of chronic diseases and to determine unacceptable levels of environmental contaminants that are then regulated and monitored by the Minnesota Pollution Control Agency. "We deal with noninfectious diseases and exposures to contaminants, and we deal with everything in the workplace, including infectious diseases like hepatitis," Bender explains.

Of all the issues Bender and Soler address, cancer is by far the No. 1 concern. About two-thirds of their division's time is spent on the Minnesota Cancer Surveillance System, an eight-year-old effort that gathers information on all newly diagnosed cancers in the state. Its purpose is to provide perspective on the incidence of each type of cancer, "not to serve as an early warning system for environmentally related cancers," Bender says. He explains that many states have established this kind of registry because of the false belief that such a system can detect "breakouts" of environmentally related cancers.

"It's hard to explain even to scientists that morbidity data tend to move like a yo-yo," says Bender. "If you take a swatch from a period of time, you can find anything from one extreme to the other, and if you react to that you cause multiple harm.

"The Health Department or any other legitimate research organization doesn't just waltz into a community and announce, 'We're going to do a study,' without having a major impact on the people in that community," Bender continues. It's an ethical issue, he says, comparable to a physician deciding if the benefit of an aggressive procedure merits the risk to the patient.

Soler adds, "Even if public health officials do a study and come up with a negative finding, often the fact that a study was done affects the community forever."



"Even if public health officials do a study and come up with a negative finding, often the fact that a study was done affects the community forever."

–JOHN SOLER, M.P.H.

PHOTOGRAPH BY KEVIN WHITE

Suburban St. Louis Park offers a perfect example. In the late 1970s, the Health Department did a study because the public feared that Reilly Tar and Chemical had contaminated the water. The perception was that the incidence of breast cancer was elevated as a result. The study found that incidence levels were elevated, but for an entirely different reason. A quarter to a third of the community's population is Jewish, and Jewish women have an increased risk of breast cancer. The findings were published but did little to change public perception. "To this day, the water in St. Louis Park is double carbon filtered," says Bender. "And upwards of 20 percent of people in that community still use bottled water."

Soler says the problem with epidemiologic studies that attempt to find out if health problems are caused by a specific environmental factor—electromagnetic frequencies, for example—is proving something doesn't exist. "When you come to the public with that language, it doesn't put to rest the issue, and that's unfortunate."

Bender believes that health professionals and the public must learn to focus on the preventable causes of cancer and early detection and treatment, because cancer is likely to increase in overall incidence as average life expectancy increases and the baby-boomer generation reaches old age. "We can't afford to spend billions of dollars chasing molecules around the environment even though there's virtually zero possibility that they're impacting our health," he says. ⇨

Next spring Bender's Chronic Disease and Environmental Epidemiology Section hopes to put to rest the idea that something insidious in the environment is causing outbreaks of cancer. "We're going to publish all the cancer elevations that have occurred in Minnesota over the past eight years, over 23,000 of them," he explains. "Many [of my colleagues] are saying that people are just going to use that to say 'Aha! We told you there's way too much cancer out there.' Well, the fact is that it's all explained. There hasn't been a single observation we've encountered that can't be explained by the distribution of cancer in the state."

The Minnesota Department of Health recently added to its environmental watch by instituting a Birth Defects Surveillance System. Bender expects that system to tell more about the environment than does the cancer surveillance system. "The latencies are much shorter," he says. "You don't have decades of time lag where people move, and you can get some reasonable handle historically because you don't have all the other life events to sort out."



PHOTOGRAPH BY DAVID ROSE

"Groundwater contamination is one of the leading concerns in environmental medicine."

–Robert Orford, M.D.

Dr. Detective: Investigating Patient Ailments

While Bender and Soler, as epidemiologists, work with the community as a whole, Robert Orford, M.D., practices occupational and environmental medicine with individual patients. Orford, who until recently was chair of the Minnesota Medical Association's Environmental Health Subcommittee and is past president of the North Central Occupational and Environmental Association, transferred from the Mayo Clinic in Rochester to the Mayo Clinic in Scottsdale, Arizona, in October 1996. There he sees patients referred by physicians who suspect that an ailment might be caused by an environmental exposure. Orford's job—to identify which environment and what type of exposure might be affecting the patient—often requires the investigative prowess of a Sherlock Holmes.

The case of the red dust

Orford was just beginning his practice in environmental and occupational medicine when the community hospital resident called for a consultation. The resident knew he had an unusual case to be solved. The patient was a 21-year-old man with pulmonary hemorrhage typical of Goodpasture syndrome, but without the usual accompanying acute glomerulonephritis. Orford donned his detective hat and headed for the hospital.

A complete history revealed that the young man had recently been working with some "red dust" at his job, but he didn't know what it was. A call to his company produced a tepid response, but a grudging approval for Orford to look at their medical records. That's where he found the smoking gun.

"There had been about 10 similar cases in the past couple of years, including one severe case that had been diagnosed as atypical Goodpasture syndrome," Orford recalls. "I tracked that patient down and found out that he had been hospitalized for several days, had gotten better and went back to work, and then had a relapse. He was hospitalized several times, and each time he got better and went back to work, the symptoms returned. He told me that he had to quit the job, 'because it kept making my Goodpasture syndrome worse.' "

Orford obtained a sample of the red dust for analysis. The lab identified it as trimellitic anhydride, but a check of the toxicology literature came up empty. He had identified a new toxic substance. "I went back to the company and helped them work out some safety measures for handling the substance, and that took care of

the problem." Then Orford wrote the case up and got it published to alert industry and the fields of toxicology, environmental medicine, and occupational health.

The case illustrates several things about environmental medicine: its similarity to detective work, the importance of referrals from colleagues, the need for cooperation from companies or whatever entity controls the exposure site, and the satisfaction that can come from not only helping a patient but also identifying a new toxic substance and the safety precautions it requires.

In search of the truth

In Arizona, Orford is already seeing a major difference from Minnesota patients. "There's a lot of eye irritation and asthma aggravation from the air pollution down here, something I wasn't used to in Rochester."

What Orford *was* used to in Minnesota was concern about water pollution, especially that caused by agricultural runoff and toxic contaminants such as dioxin, DDT, and PCBs. "Groundwater contamination is one of the leading concerns in environmental medicine," Orford says, but it is also one of the hardest to investigate. Why? Drinking water and patients' body fluids seldom reveal measurable levels of toxins. And it can take years or generations for environmental toxins to have an effect, so it is hard to track down a culprit, assuming one does exist.

This is a typical dilemma in environmental health. Occupational health, on the other hand, deals with a specific environment where it is often easier to associate a toxin to an acute ailment. But even at a job site, a physician's detective work can be challenging, because a patient's problem might be caused by any of the other environments he or she frequents. "My job is to find the truth, if that is possible," Orford says. "Sometimes it's not."



"We need low-cost screening methods that can be used to increase the number of individuals we can screen in research and for routine testing in clinics."

–Vincent Garry, M.D.

PHOTOGRAPH BY KEVIN WHITE

The Academic Detective: Solving Environmental Mysteries

The earth is indeed the laboratory for physicians working in environmental medicine. Another veteran environmental detective, Vincent Garry, M.D., is sleuthing environmental mysteries throughout the state. As director of environmental medicine and pathology at the University of Minnesota, Garry, like Orford, sees patients, but his larger interest is environmental research.

The case of rising birth defects and falling fertility

Malformed frogs discovered in Minnesota have drawn national—even international—attention in recent months. Some scientists suspect that parasites are responsible for altering development in frogs, causing them to have extra, underdeveloped limbs. But concern about environmental toxins is clearly spurring the widespread interest.

This past September, the Minnesota Medical Association House of Delegates passed a resolution, introduced by Kent Wilson, M.D., MMA president-elect and trustee, calling for the MMA to "support and encourage scientific efforts to investigate the causes of anomalies in the Minnesota frog population and their possible relationship to human birth defects," and to "work to reduce the biologic impact of identifiable etiologic agents."

This reference to birth defects is related to another current environmental mystery that Garry has been investigating. An analysis of statewide birth records from 1989 through 1992 revealed that birth defects were significantly higher—for some types two to three times higher—among children born to farmers licensed to use pesticides, compared with the incidence of birth defects

in the general population. When the statistics were analyzed by agricultural, forest, and urban areas, birth defects were more common in agricultural areas, leading to suspicions about groundwater contamination by pesticides and fungicides.

In September 1996, Garry received a $2 million, five-year grant from the National Institutes of Health to study health, fertility, and reproductive risk associated with pesticides. The project will study 70,000 individuals in the five-county area of northwestern Minnesota, including the Red River Valley.

In the first of the five years, Garry will focus on the hypothesis that reduced fertility is associated with pesticide application. Semen samples will be collected during the application season and during the off-season from appliers in the three Minnesota counties with the highest chlorophenoxy (2,4-D type) herbicide and fungicide use. Laboratory analyses will evaluate male fertility, including sperm counts, critical morphology, and motility.



Garry sees the project as a chance to find out if the association between pesticide exposure and chromosomal damage and birth defects is real or not, but also as an opportunity to work cooperatively with family physicians and Minnesota Extension Service agents in the area. "I hope to be able to spin off sufficient collegial relationships to build a long-term environmental medicine and toxicology network for the benefit of the state."

He also sees it as a chance to look closely at a phenomenon that worries many: average sperm counts have reportedly declined by about 50 percent in recent decades. Some see this as the legacy of exposure to environmental contaminants that are hormonal analogues; others see it as a questionable observation based on anecdotal reports from laboratories whose methods of sperm analysis have changed over time. "Maybe the sperm count is down, maybe it's not," says Garry. "To find out whether it is and whether there are environmental contaminants involved, we have to look at rural versus urban populations and obtain sperm counts across seasons to look for temporary variations in people exposed to different chemicals. Such studies are extremely difficult technically, ethically, and for other obvious reasons," he says.

Chromosomal abnormalities

Garry also has studied chromosomal abnormalities in 61 pesticide appliers compared with 33 unexposed control subjects. In the pesticide workers he reported finding breaks and rearrangements on chromosomes 14 and 18, which have been linked to an increased risk of non-Hodgkin lymphoma. No such abnormalities were found in the control subjects. While he can't conclude from these preliminary studies that pesticide exposure causes long-term health effects, the findings clearly indicate the need for more research.

Toxin exposure and screening

The State of Minnesota helps support Garry's toxicology laboratory through a special grant that pays for investigation and analysis of potential toxic exposures throughout the state. "Our paradigm is to look at environmental medicine in the total human environment, taking into account both the exposure to chemical X and whether the individual is a heavy smoker or drinker or has other characteristics that will cause them to process the chemical differently. We use the tools of toxicology, pathology, and epidemiology to provide a service to the state that is designed around identification and prevention," Garry says.

A major factor impeding the study of exposure to environmental toxins is the technical complexity and cost of screening individuals. Currently, scientists determine agrochemical toxicant levels using gas chromatography combined with mass spectrometry, methods that cost approximately $800 per urine specimen. "What is needed is low-cost screening methods that can be used to increase the number of individuals we can screen in research and for routine testing in clinics," he says.

Thanks to a grant from the Blandin Foundation of Grand Rapids, Minnesota, Garry is in the process of developing such a test. The $140,000 grant is from Blandin's SOTA TEC Fund, which supports the development of new technologies by University of Minnesota faculty working in collaboration with Minnesota companies, preferably for the benefit of rural Minnesota communities. Garry is collaborating with Robert E. Carlson, Ph.D., president of ECOCHEM Research, Inc.,



SPECIALIZE IN AIR FORCE MEDICINE.

ER Physicians. Radiologists. OB/GYNs and other specialists! Today's Air Force gives you the freedom to specialize without the financial overhead of running a private practice. Talk to an Air Force medical program manager about the tremendous benefits of becoming an Air Force medical officer:

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay each year

Examine your future in the Air Force. Learn if you qualify. Call

USAF Health Professions
Toll Free
1-800-423-USAF

AIR FORCE

in Chaska, to develop a cost-effective screening kit and analysis service for pesticide and herbicide exposure.

Garry and Carlson believe they can develop a test based on immunoassay technologies, which are used to quantify trace molecules in the blood and urine, mainly to assess levels of therapeutic drugs and drugs of abuse. Their immunoassay screening kit will test for the most commonly used agrochemicals: lindane, pentachlorophenol, chloropyrifos, chlordane, DDT, dieldrin, dicamba, and 2,4-D. Chloropyrifos, dicamba, and 2,4-D are the most commonly used pesticides in Minnesota agriculture.

Compared with the $800 cost of chromatography and spectrometry analysis, Garry and Carlson estimate that their immunoassay screening kit and testing service will provide answers for about $20 per analyte, for a total of $160 if all eight chemicals are screened.

Academia: Bringing All Sides Together

Even given the best tools to monitor environmental toxins and the most comprehensive research on their effects, how do we as a society decide which substances to ban and which to tolerate? That puzzle involves many factors and players, including environmental activists, industry lobbyists, scientific experts, community organizations, and the influence they have on the media, general public opinion, and public officials.

Trying to understand this puzzle and to help fit its pieces together more effectively is the challenge of the Center for Environment and Health Policy at the University of Minnesota School of Public Health. Director Ken Sexton says one of the center's goals is to strengthen the role of science in regulatory decision-making by serving as a link between scientists and policymakers. He says one of the key issues in environmental health is how to assess risks and focus available resources on the worst risks. "There is a 'hard' version, where experts convene to look at scientific information about risks and then rank them," says Sexton. "And there is a 'soft' version, where you bring in public opinion as important to reflect societal values, and you merge that with the expert opinion."

Few question the policymaking and budget-driving power of public opinion, especially when politicians are confronted with public outrage over perceived risks that are involuntarily imposed on innocent victims, such as students exposed to asbestos in schools. Therefore, if they want to have more involvement in environmental policy, scientists need to better understand how their research and opinions affect public perceptions, Sexton says.

"Our issues are not just health issues," adds center deputy director Ian Greaves. "They are life issues. We want cheap fuel for our cars, homes, and industries, but we don't want the air pollution and environmental damage that result. We want simple solutions to complex problems."

In the proceedings from a May 1996 conference on environmental policy, Sexton, Greaves, and Barbara Scott Murdock, a senior fellow at the center, suggest five attributes of better environmental decisions: sustainability, accountability, effectiveness, efficiency, and equity. And they stress the importance of partnerships in making decisions.

"Environmental protection is a shared responsibility. Government, businesses, and communities should recognize this fact by forming and nurturing environmental partnerships that take joint responsibility for identifying important problems, finding mutually agreeable solutions, and evaluating progress."

How can the community of physicians, scientists, government, industry, and lay people work together to develop environmental policy and take action? The center has just begun a Community Partnerships Project to gather some ideas. Sexton and Murdock are directing the project. In a pilot phase, they want to find out what is working, what are the barriers, and what are the resources for environmental partnerships involving government, business, and the community. Then they will look for foundation funding to spread the word about what it takes to get such partnerships going and keep them effective.

Clearly, the stakes are high for decision-making at all levels of environmental action. As Sexton, Murdock, and Greaves write in "Environmental Policy in Transition: Making the Right Choices," "Our future well-being and the welfare of generations to come depend on environmental decisions we make today." MM

Michael Moore is director of communications at the William C. Norris Institute and Norris Education Innovations, Inc., in Bloomington, Minnesota.

Dr. Harold C. Deutsch
World War II History
Roundtable

Thursday, February 13, 7 p.m.
Fort Snelling History Center Theatre

TOPIC:
"Saving Lives on the Battlefield:
The Combat Surgeon"

SPEAKERS:
Bill McConahey, M.D., and Charles Aling

Hosted by Minnesota Historical Society.
Open to the public. No charge for
admission, but donations requested.

QUESTIONS?
Contact Don Patton at 612/835-7600

Watch for *Minnesota Medicine*'s February issue, which will focus on military medicine and include a profile of Dr. McConahey.

EQUIPMENT LEASING *MADE easy*







Whether you need the latest in diagnostic equipment for your exam room or a new computer for the business office, MMBR Equipment Leasing offers health professionals a truly versatile, service-oriented leasing program. *One-stop shopping.* MMBR Equipment Leasing provides a single location for the leasing funds you need, with 15 different funding sources. This ensures you're getting the best rates available. *Easy processing.* You can access to up to $125,000 from a one-page application, and get approval within 24 hours. With MMBR Equipment Leasing it's as simple as a phone call. *Plans specially developed for you.* Customized lease plans are available that provide $2,000 to $2,000,000+ at terms that fit your needs. Ask about our lease options that require no personal guarantee. *Just another equipment leasing company? Not even close.* Whatever you need for your lab or office, whether you're in a start-up or established practice, MMBR Equipment Leasing makes getting it easy. For personal attention and unparalleled service, call 623-2860, or toll free 800-298-MMBR (6627).

MMBR

EQUIPMENT LEASING

MINNESOTA MEDICAL BUSINESS RESOURCES

OWNED BY MMA & HMS

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.

3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Rescue Worker and Population Protection in Large-Scale Contamination Disasters

Victor S. Koscheyev, M.D., Ph.D., Sc.D., and Gloria R. Leon, Ph.D.

ABSTRACT

We discuss disaster preparedness and emergency response to large-scale disasters. Our particular focus is disaster management and protection of disaster response personnel in situations involving chemicals and radiation. We describe a unit system that protects rescuers working in the epicenter of a disaster, and we examine effective protective clothing and procedures for enhancing human performance in extreme environmental conditions. We also present an outline of patient triage in response to radiation disasters. Finally, we describe recent efforts underway in Minnesota to prepare for managing large-scale disasters.

The terrorist bombings of the World Trade Center in New York and the Alfred P. Murrah Federal Building in Oklahoma City illustrate the threat of new and dangerous disaster situations in the United States. International experience after large-scale disasters such as the nuclear power plant explosion at Chernobyl in the former Soviet Union and the more recent Kobe earthquake in Japan is sobering. The United States and other countries do not yet have the knowledge and technology to ensure optimal performance of rescue and work teams and to protect the population in the epicenter of a disaster. Many organizations and governments conduct training exercises, but we have little knowledge of how to respond in an actual disaster.

Extremely complicated logistical problems arise when a disaster involves toxins such as chemicals and radiation. These problems are particularly acute when an extensive area and a large population are contaminated, as occurred at Chernobyl. The multiple federal, state, and local systems the United States has in place for disaster management would make an effective response difficult because a catastrophic contamination demands quick organization and integration of activities.

The World Association of Disaster and Emergency Medicine now recommends that countries concentrate their disaster preparedness at the community level.[1,2] However, the scale of a number of previous disasters was so large that local facilities and medical teams could not effectively respond either during or after the event.

The Chernobyl experience gave birth to many scientific problems involving the choice of technologies for conducting comprehensive health screening of disaster workers and the large local population at different stages after a contamination disaster.[3] Health care must be provided throughout the entire life of the patients and all affected groups. This issue is even more difficult than evaluating victims in the acute period following a disaster, which can range from hours to days. Over time, the health and financial costs of the mid- and long-term consequences of large-scale disasters are much greater than acute-stage effects and so must be considered separately.

Many of the observations and recommendations made in this article are based on author Victor Koscheyev's experience as the first medical officer at Chernobyl and his subsequent organization of the Specialized Center for Disaster Medicine "Protection" in Moscow, which he directed before coming to the University of Minnesota.

Protecting Workers in a Contaminated Environment

A disaster site requires many different types of workers. They include firefighters, reconnaissance teams to assess the type and extent of contamination, personnel with equipment for search and rescue from collapsed buildings, and medical teams to provide triage and advanced trauma life support. Mental health disaster responders provide emotional support to the affected population and to disaster workers.

Disasters that have multiple components—such as a collapsed or exploded building complicated by some form of contamination—create special circumstances for the people involved. How do we protect the rescue team working in the epicenter of

the disaster? How do we deal with the medical and psychological consequences of the extreme stress that rescue workers and the general population experience as a result of the disaster? How do we monitor the immediate and long-term health of the affected population? Effective disaster management includes efforts to lessen the severity of the work conditions for response personnel, to mitigate deleterious health factors, and to evaluate short- and long-term health consequences.

Rescue teams have the most difficult mission. They must perform several tasks in the epicenter of the disaster in a short period of time while under high physical and mental pressures. For example, rescue workers might simultaneously struggle with a fire, evacuate and provide medical help to victims, and remove barriers. The Oklahoma City bombing provided a clear example of the types of activities required to respond to a terrorist bombing. Disaster management is even more complex when the situation involves radiation or chemical contamination.

An integrated response

Rescue work in the epicenter of a disaster involving contamination requires an integrated system. A series of functional structures, which we call units, should be arranged as needed at staggered distances from the epicenter.

Unit 1 has the highest priority and handles reconnaissance, in which the response team evaluates the scope of the devastation and the extent of contamination. A Unit 1 structure is situated closest to the epicenter and is constructed so that workers are intensively protected. A structure with interior and exterior walls shelters the reconnaissance team; each wall has openings with protective airlocks. A protective suit is located in the space between the walls, connected to the interior wall airlock. After moving through the interior wall airlock and donning the protective suit, the worker egresses from the exterior wall airlock to the outside environment. The standard procedure for putting on and taking off the suit through the airlock was adopted from the nuclear industry. NASA is also using this procedure to protect crew members from abrasive dust while on the planned Mars mission.[4] A Unit 1 structure protects rescue workers from severe environments (e.g., -100 C to +100 C) and allows them to monitor their surroundings, take samples, perform simple mapping and situation analysis, and choose the best route for the movement of different types of specialized cars and equipment (graders, excavators).

Unit 2 contains robotics equipment used to clear pathways to the epicenter, although sometimes robots malfunction because contamination interferes with their electronic systems. At Chernobyl, for example, robotic equipment was inoperative for two to three months because of the high level of radiation in the area.

Emergency crews use Units 3 and 4. These units contain protective equipment necessary for continuous work in extremely dangerous surroundings. This equipment includes protective breathing systems, garments, and shoes with all components coordinated to promote optimal work performance, and life-support systems that provide long-term comfort for rescue workers.

Unit 5 provides paramedic-patient transport to a specially equipped mobile hospital at the periphery of the disaster site. Patients receive initial medical help on a shuttle while they are being transferred to this facility.

Unit 6 contains field facilities where rescuers and other disaster workers can rest and obtain psychological support.

Protective equipment

All groups responding to a disaster should have standardized equipment and procedures. In particular, rescue workers need to be comfortable; protective equipment must be designed to prevent deleterious physical effects. For example, local and general pressure on the head and lack of heat transfer through layers of protective equipment create considerable problems, and the rubber masks rescue workers wear for protection can freeze the skin in cold conditions.

The equipment first responders use must be capable of producing air or water current in plastic tubing under the protective suit in a wide range of temperatures (-100 C to +100 C). To protect workers, suit design and materials need to be hygienically acceptable. Whenever possible, equipment should increase the range of normal functioning of different physiological systems in response to physical stressors.

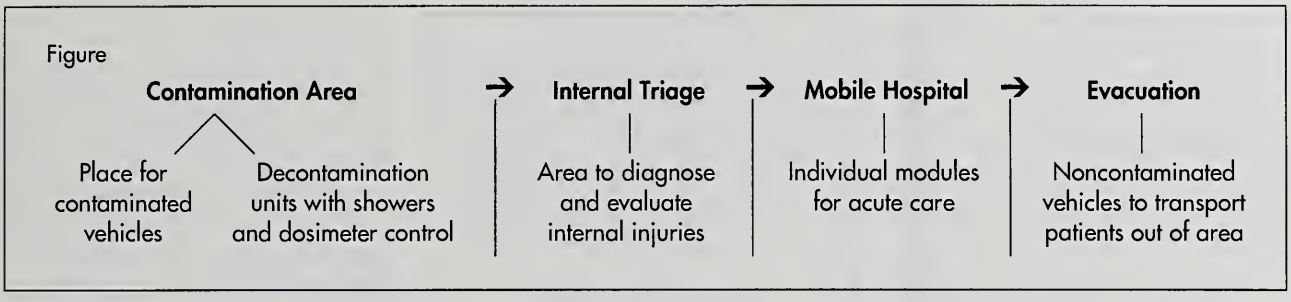
In general, while wearing regular clothing and working at a normal rate under normal temperatures, the body remains comfortable. It transfers sufficient heat to the atmosphere through radiation, convection, and sweat evaporation. However, when rescue workers are insulated from the surrounding air by nonbreathable clothing, most of their body heat is trapped, thus increasing their core temperature. A combination of high temperatures, heavy or insulated clothing, and above-normal exertion can quickly lead to heat stress.

To reduce heat casualties and water consumption, increase work output, and improve the psychological performance of rescue workers, it is necessary to create an individual microclimate cooling system. Many different cooling technologies exist: a wet cover, ice base, foot pump, ambient air, vortex tube, ejector cooling, carbon dioxide (phase change), endothermic reaction, heat pipe, solid absorption, liquid absorption, vapor compression, and thermoelectric devices. Exploring multiple cooling technologies, optimizing vapor C components, and developing new protective equipment should provide individuals and the work group greater protection and improve work effectiveness.

Work shifts and psychological support

The physical and mental stress rescue workers experience working in the epicenter of a disaster must be minimized. Disaster management research needs to evaluate the effects of varying work activity requirements and working in shifts (which sometimes causes sleep deprivation) and individuals' different emotional reactions to disaster stressors.

Figure



Because of the arduous labor and temperature extremes, rescuers should work in shifts. After each shift, disaster workers need psychological and psychophysiological support such as relaxation training for rapid, one-stage normalization to mitigate the effects of their work. One effective method for normalizing the body as soon as possible after hard work and high temperature exposure is for workers to don a specially designed plastic tube cooling suit or to use an enclosure with regulated temperature walls.

Additional problems for rescuers include exposure to constant dosage levels of contaminations and the development of burns of the mucosa (eyes, larynx, etc.). Workers must be removed quickly from these situations. A subsequent problem is finding enough highly experienced personnel. Sometimes hundreds of workers must be rotated after only several minutes of activity in the epicenter of a disaster, as was the case at Chernobyl.

Triage

Triage at the epicenter of a disaster is one of the most difficult challenges in emergency medicine, and response priorities and procedures need to be enhanced.

Deploying triage facilities close to the epicenter of a radiation, chemical, or biological disaster is a serious mistake. The mobile hospital's equipment and tents are quickly destroyed, high levels of contamination occur within, and personnel are exposed to great health risks. Disaster management strategies must avoid these conditions while at the same time enable the provision of full medical services at contaminated sites, which could encompass a huge area and an enormous number of people.

The figure presents a diagnostic and prehospital system for patient triage after a radiation accident. Contaminated vehicles bring patients from the disaster site to a designated area. Adjacent decontamination units contain showers and equipment for biological dosimetry of external radiation. Internal triage diagnoses and evaluates internal radiation. Patients are then moved to a mobile hospital with several modules for immediate acute care. Finally, patients are placed in noncontaminated vehicles for transport out of the area.

Technologies for dealing with the health impact of a disaster such as Chernobyl should include mobile medical or triage systems, which can be brought into local communities to quickly screen and evaluate the physical and mental health of the population. Medical and scientific specialists who reside in the area, along with outside experts, can then conduct evaluation, treatment, and research.

Medical response priorities

Rescue workers should be the first priority for medical evaluation and intervention because they are the group most susceptible to health hazards. They exert themselves physically for long periods of time and experience psychological stress.

Many people who have worked at the epicenter of various disasters have suffered severe and long-lasting psychological consequences from even a few minutes of viewing dismembered bodies, dead or alive, or because of uncertainties about personal health outcomes.[5] In fact, concerns about personal long-term health status is a particular issue for people involved in contamination disasters. Many Chernobyl disaster response workers were not able to recover psychologically from their work conditions or cope with the aftermath of uncertainty about their future health. Suicides, emotional disorders, substance abuse, and family and work problems have been reported in large numbers.[6,7]

The next priority is the population exposed to very harsh environmental conditions as a result of living in the area where the disaster occurred. This population may suffer from various physical and psychological problems. The conditions engendered by the disaster may continue for a long time and lead to different types of health consequences over time.

Medical response procedures

Relatively uncomplicated industrial accidents have provided experience and practice with small-scale radiation emergencies. While disaster response planning by the United States and the former Soviet Union has been oriented primarily to a nuclear war scenario,[8] traditional criteria may not identify which individuals were exposed to radiation following smaller-scale radiation accidents or terrorist bombings. In contrast to the situation after a nuclear bombing, people display no visual signs of injuries or obvious symptoms such as eardrum or lung ruptures, eye injuries, or burns. With some injured persons, vomiting does not occur until after 100 rem and only after 200 rem in all persons. Gastrointestinal syndromes may appear only after a dosage level of 600 rem.[9,10] Therefore, simple, informative methods that can be used in field situations are essential to quickly diagnose lesser but medically important exposure levels in large numbers of people.

Field procedures include physical dosimetry, physical examination, and blood analysis. Clinical symp-

toms that would indicate an individual needs immediate attention include gastrointestinal signs (nausea, vomiting, or diarrhea), neurological signs (asthenia, weakness, headache, meningeal symptoms), and vasomotor signs (erythema of skin and mucous membranes, profuse sweating). Blood analysis includes assessing levels of leukocytes, neutrophils, and lymphocytes. The delay in the onset of vomiting can provide information on the level of radiation exposure. Medical personnel can use more sophisticated and accurate diagnostic measures as soon as patients have been transferred to specialized clinics for radiation victims.

Recent Minnesota Efforts in Disaster Research

Efforts are underway at the University of Minnesota to establish a Health Protection Center. The goals of the center are to conduct research, education, and training in three areas: disaster response planning, health surveillance among populations subjected to large-scale disasters and environmental contamination, and the protection of human health and enhancement of performance under extreme environmental conditions. The center will follow a multidisciplinary model joining together basic science and applied research in both laboratory and field situations. Members of the center include academic as well as federal and state of Minnesota emergency response personnel.

In an effort spearheaded by the Minneapolis Veterans Affairs Medical Center Office of Emergency Medical Preparedness, various center members are conducting an exercise of a radiation disaster occurring in the extreme cold. Radex North, as the exercise is called, will be useful for testing response strategies and rescue worker protective equipment in the kinds of winter weather conditions specific to Minnesota and other northern states. The exercise will also be useful in developing and practicing decontamination strategies for large numbers of people in a cold environment.

Conclusion

A number of disaster management problems exist for which we are not yet prepared. They need to be solved. We must develop more comprehensive strategies for protecting the health of disaster workers and the greater population and for delivering more effective emergency and follow-up medical and psychological services to those affected by large-scale disasters. This article addresses only a few such strategies and services. Health professionals in academic and public sectors must collaborate in order to enhance immediate protection and long-term health outcomes, particularly after complex disasters involving contamination. MM

Acknowledgment

Portions of this paper were presented at the Metropolitan Emergency Medicine Forum in Minneapolis on October 17, 1995.

Victor Koscheyev is a professor and senior fellow in the School of Kinesiology and Leisure Studies, College of

ASPEN Medical Group

Family Practice
Internal Medicine
Full-Time Urgent Care

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

ST. CLOUD MEDICAL GROUP, P.A.

St. Cloud Medical Group,
a 38-physician multi-specialty clinic, is now recruiting BC/BE physicians in the following specialties:

- **Pediatrics**
- **Family Practice**
- **Urgent Care**

Guaranteed first-year salary. Production program thereafter with a full fringe benefit package.

If interested in joining a progressive medical clinic in central Minnesota, call or send CV to:

Daryl G. Mathews
Administrator
St. Cloud Medical Group
1301 West St. Germain
St. Cloud, MN 56301
(320) 251-8181

Education and Human Development, at the University of Minnesota. Gloria Leon is a professor in the Department of Psychology at the University of Minnesota.

REFERENCES

1. World Association for Disaster and Emergency Medicine. Priorities in medical response to disasters. Prehospital Disaster Med 1990;5:64.
2. Kirsch TD. Disaster preparedness and response as a primary health care. Prehospital Disaster Med 1995;10:223.
3. Koscheyev VS, Leon GR. Strategies for test battery selection for screening large-scale populations exposed to radiation disasters. Minneapolis: University of Minnesota, 1994.
4. Cohen MA. The suitport's progress: AIAA Life Sciences and Space Medicine Conference: 3-5 April 1995; Houston, Texas. Washington, D.C.: American Institute of Aeronautics and Astronautics, 1995.
5. Mitchell JT. Stress: the history, status and future of critical incident stress debriefing process. J Emerg Serv 1988;13: 47-52.
6. Russian newspaper article in Moscovskii Komsomoletz 1994 August 24.
7. Mosgovaya AV. Social consequences of the Chernobyl catastrophe: some results of sociological research: preliminary paper 198. Dover, Delaware: Disaster Research Center, University of Delaware, 1993.
8. Pretto EA Jr, Safar P. National medical response to mass disasters in the United States: are we prepared? JAMA 1991;266: 1259-62.
9. United Nations Scientific Committee on the Effects of Atomic Radiation. Sources, effects and risk of ionizing radiation: report to General Assembly. New York: United Nations, 1988.
10. Koscheyev VS, Leon GR, Greaves IA. Lessons learned and unsolved public health problems after large-scale disasters. Prehospital Disaster Med. In press.

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Internal Medicine
Occupational Health

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES

LICENSED LOCUM TENENS PHYSICIANS

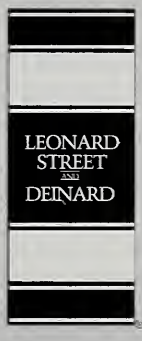
Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell
Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
or 800-295-6373
Fax: 682-4791

Creative solutions for all your health law problems



Leonard, Street and Deinard
Suite 2300, 150 South Fifth Street, Minneapolis, Minnesota 55402

For information call
Daniel J. McInerney, Jr.
Chair of the firm's Health Law Group
(612) 335-1500

Quality legal representation and community service since 1922

Special Early Factory Order Pricing on New 1997 Sport Utility Vehicles Through MMBR Motor Services

Remember, whether you purchase or lease, MMBR Motor Services and Creative Leasing, Inc. will help you get the most vehicle at the best price. We'll even help you sell your old auto.

Use your money wisely. For personal attention and lease or purchase information on any vehicle, call 612/623-2860, or toll-free 800/298-MMBR.

MMBR Motor Services is a service of Minnesota Medical Business Resources, a physician-owned corporation of your medical association.

New Vehicle Leases**

Make/Model	MSRP	Your Price*	24 Mo	36 Mo	48 Mo	60 Mo
97 GMC Jimmy SLS 4dr	$26,947	**$24,790**	$429	$353	$328	$318
97 Chevrolet Blazer LS 4dr	$27,357	**$25,136**	$419	$357	$323	$322
97 Ford Explorer XLT 4dr	$28,880	**$26,025**	$385	$347	$325	$332
97 Jeep Grand Cherokee Laredo	$28,188	**$26,149**	$441	$373	$341	$332
96 Nissan Pathfinder SE	$30,618	**$28,568**	$472	$407	$372	$355
97 GMC Yukon SLE 4dr	$32,999	**$31,327**	$464	$414	$391	$375
97 Chevrolet Tahoe LS 4dr	$32,935	**$31,270**	$464	$413	$391	$375
97 Chevrolet Suburban 1/2 LS	$36,457	**$34,293**	$541	$476	$446	$424
97 Toyota 4-Runner SR5 4dr	$31,953	**$30,549**	$507	$429	$382	$349
97 Mitsubishi Montero LS 4dr	$31,690	**$30,361**	$546	$476	$446	$409
97 Ford Expedition XLT 4dr	$33,645	**$31,259**	$421	$398	$387	$369

* Sale price before tax, license, license fees, and 1997 price increase.
** All lease payments listed above are monthly lease payments before tax on factory ordered leases. These lease payments are based on a $0.00 cap reduction and 15,000 miles/year. The only moneys needed to start the above leases are first payment, security deposit, and license for the first year.



MMBR

MOTOR SERVICES

MINNESOTA MEDICAL BUSINESS RESOURCES OWNED BY MMA & HMS

Conducting Truck Drivers' Physical Exams

The High Prevalence of Sleep Apnea

Comprehensive physical exams are of utmost importance given truck drivers' high risk for sleep apnea and other sleep-related breathing problems.

Donald S. Asp, M.D.

Editor's Note: During the 1996 Minnesota legislative session, the Minnesota Medical Association defeated a proposal that would have granted chiropractors the authority to perform physical examinations on truck drivers. A similar proposal is likely to be debated during the 1997 legislative session.

Obtaining a medical history and performing a physical examination (H and P) are the first clinical skills taught to medical students. Throughout residency training and during practice, physicians use some variation of these basic skills with each patient. The clinical knowledge garnered through lectures, teaching rounds, journals, books, and personal experience, combined with the technical skills physicians learn during extensive training, allow physicians to competently synthesize information gathered during the H and P and to properly diagnose and treat patients.

Primary care physicians frequently see "history and physical" listed for upcoming patients. These examinations may be required for a number of reasons, including regular health maintenance, athletic participation, or employment qualification. Whatever the reason, the H and P is never routine, and, therefore, requires careful attention.

Truck drivers provide an interesting example of the importance of such examinations. Truck drivers are subject to unique stresses and are frequently sleep deprived, which, when combined with preexisting physical conditions, can contribute to an increased risk for highway accidents.[1] Nationally, trucking accidents cause more than 5,000 fatalities and 30,000 injuries a year.[1] The American Trucking Association (ATA) and physicians examining truck drivers are committed to eliminating preventable accidents. Truck drivers are required to pass set standards for vision, hearing, and blood pressure, and to have complete physical examinations.[2] During these checkups, physicians often discover medical conditions that can be treated to reduce the risk of accidents. In particular, truck drivers are at high risk for obstructive sleep apnea and other sleep-related breathing disorders.

Sleep-Related Breathing Disorders

Obstructive Sleep Apnea (OSA) is at "the extreme end of the sleep-related breathing disorders."[1] Milder forms include hypopnea, which is a reduction in airflow through the nose and mouth.[3] Individuals with full-blown OSA have frequent apneic/desaturation episodes, which interrupt their sleep. Current estimates indicate that OSA affects between 4 percent and 8 percent of the general adult population.[4] However, a continuum of sleep-related breathing problems affects a much higher proportion of the population.

Evidence indicates that a high percentage of truck drivers experience interrupted sleep and symptoms of sleep apnea syndrome. Investigators from Stanford University conducted a thorough study over a three-week period in a trucking company hub.[1,5] The study included questionnaires and psychological tests, such as monitoring the truck drivers during sleep for heart rate, snoring sounds, oxygen desaturation, and body position and movement. Results showed that 78 percent of the truck drivers tested had an oxygen desaturation index (ODI) in the abnormal range, using five or less per hour as normal.[1] Applying a more conservative normal ODI range of 10 or less per hour, investigators still found that 46 percent of truck drivers tested in the abnormal range.[5]

In Minnesota, inattention/distraction was the leading cause of truck crashes (21.6 percent) in 1995. Many of these accidents may be the result of sleep-disordered breathing.[6] In the Stanford study, truck drivers with sleep-disordered breathing caused twice as many accidents as drivers free of this problem.[5] A Wisconsin study of state employees found sleep apnea in 4 percent of middle-aged men and demonstrated that "drivers with sleep apnea have a three to seven times greater risk of accidents than drivers without the disease."[7] The Foundation for Traffic Safety has suggested that sleep apnea plays a role in from 1 percent to 10 percent of the 20 million automobile accidents per year nationwide.[8] ⇨

Truck drivers are continually making minor steering adjustments, which require constant attention to the road. The ATA is working to improve truck driver recognition of inattentiveness through educational programs on "alertness indicators."[8] These indicators include yawning, head nodding, closing the eyes, staring, and wandering thoughts, all of which can precede dozing at the wheel. The ATA is also conducting extensive studies of sleep apnea among its workers.[2]

Truckers' Physical Exams

Physicians need to identify and correct medical conditions that contribute to truck drivers' inattention or sleepiness while driving. Physicians performing physical examinations for truck drivers must be aware of the subtle as well as the more obvious findings suggesting sleep apnea and sleep-disordered breathing.

Findley and colleagues have demonstrated improvement in simulated driving tests after treatment of sleep-disordered breathing.[9] In addition to treating truckers for sleep apnea, physicians can treat contributing and associated conditions, such as obesity and hypertension. Anatomic disorders such as macroglossia, an enlarged or low-lying uvula, and adenotonsillar enlargement partially obstruct breathing and may require surgical intervention.[3] Physicians frequently treat milder cases with medication, exercise, and a modified diet. The moderate to more severe forms of sleep apnea improve with continuous positive airway pressure (C-PAP) treatment.[3]

The ATA is concerned with the well-being of its drivers and takes truckers' examinations very seriously. In testimony before the Federal Highway Administration in 1990, ATA representatives stated, "The trucking industry concurs with the position of the Federal Highway Administration that the prescribed examination must be conducted under the supervision of a licensed doctor of medicine or osteopathy, and that the doctor must sign the medical certificate."[2] They did allow for physician assistants, nurse practitioners, and advanced registered nurses to perform the required examinations if under the supervision of a licensed doctor of medicine or osteopathy. However, ATA representatives opposed "any amendment to the federal motor carrier safety regulations that would authorize" health professionals with less comprehensive training to be responsible for these examinations.[2]

Conclusion

Truck drivers' lifestyles and the stresses they experience may lead to an increased incidence of sleep apnea and other sleep-related breathing problems. However, the high incidence rates found in the Stanford study (46 percent and 78 percent) were quite unexpected. Conducting careful histories and physical examinations of truck drivers will not only help these individuals, but may also increase safety on our highways. MM

Donald Asp is associate professor in the department of family practice at the University of Minnesota and chair of the Interspecialty Council of the Minnesota Medical Association.

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142



Central Minnesota Group Health Plan

HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220

REFERENCES

1. Stoohs RA, Bingham LA, Itoi A, Guilleminault C, Dement WC. Sleep and sleep-disordered breathing in commercial long-haul truck drivers. Chest 1995;107:1275-82.
2. Comments of American Trucking Association, Inc., on qualifications of drivers; medical examination. Presented before the Federal Highway Administration, U.S. Department of Transportation, 11 June 1990, Washington, D.C. Fed Regist 1990 April 12. FHWA Docket No. MC-90-6.
3. Rakel RB. Saunder's manual of medical practice. Philadelphia: WB Saunders Company, 1996:199-201.
4. Dambro MR. Griffith's five minute clinical consult. Baltimore: Williams & Wilkins, 1996:978-9.
5. Stoohs R, Guilleminault C, Dement WC. Sleep apnea and hypertension in commercial truck drivers. Sleep 1994;17:511-3.
6. Minnesota Department of Public Safety. Minnesota motor vehicle crash facts, 1995. St. Paul, Minnesota: Office of Traffic Safety, Department of Public Safety, 1995.
7. Pack AI. Sleep apnea: phantom of the night. ATA Foundation Update 1994 August/September:3.
8. Can drivers avoid falling aslep at the wheel? [Press release]. Washington, D.C.: AAA Foundation for Traffic Safety News, February 1993.
9. Findley LJ, Fabrizio M, Knight H, Norcross BB, Lafarte AJ, Surott PM. Driving simulator performance in patients with sleep apnea. Am Rev Respir Dis 1989;140:529-30.

The average 50-year-old leaves the work force at 63, and has put away just $57,056 for a retirement that will probably last over 20 years.

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED

How can you bridge the gap to afford a long, active retirement?

And then, there's college to think about for your children — In the year 2015, four years at a state university are expected to cost $42,530 — at a private college, $184,884. How will you bridge the gap to afford a college education for your children?

Because retirement and college education funding are such a concern, your association, through MMBR, has invested in the best technology and people to help you bridge the gap to your financial success. We offer educational seminars, personal financial/estate reviews and high quality products that can make the difference.

So, if you need help with your financial blueprint, talk with us. We will listen. We have the tools to help. Together we can bridge the gap to your successful financial future.



To find out more, call MMBR and ask for Barry Weber.

800-298-6627

MMBR

Minnesota Medical Business Resources
Owned By MMA & HMS

Now almost all your precious possessions can be insured in one brilliant stroke with The Atlantic Master Plan. It is designed for people who have a lot more to protect that the average individual.



With the specially designed coverage for the medical professional, it offers virtually unequaled insurance protection. You get coverage for your residences, automobiles, jewelry, furs, fine arts, collectibles and watercraft. You also get increased coverage for business property and electronic apparatus and additional time to tell us about newly acquired vehicles, watercraft and other valuables.

To find out about this unique insurance plan from Atlantic Mutual Insurance Company, call MMBR at 1-800-298-6627 or 1-612-623-2860.

AtlanticMutual

The right prescription for your personal insurance.

NAME

ADDRESS

DATE

℞

Atlantic Master Plan

This plan is administered for the members of the Minnesota Medical Association by:

The Christensen Group

MMBR

Minnesota Medical Business Resources
Owned By
MMA & HMS

MMA
Minnesota Medical Association

The Monitor
News For Minnesota Physicians

Announcements

Health Care Access Fund Surplus Is Growing

The Health Care Access Fund surplus is growing faster than anticipated. In February 1996, the surplus was projected to reach $330 million by 1999, but revised estimates predict a surplus as high as $419 million by 1999. James Schowalter of the Minnesota Department of Finance says that expenditures per MinnesotaCare enrollee are lower than expected and there are fewer single adults enrolling in the program than were anticipated.

• • •

Visit the MMA Home Page

The MMA Web site includes information on MMA legislation and advocacy, news, a staff directory, links to related organizations, discussion groups, CME information, and links to the best clinical resources and products and services. Visit the MMA home page at: www.mnmed.org

• • •

HTAC Announces Vacancies

The Minnesota Health Care Commission's Health Technology Advisory Committee (HTAC) is currently seeking applicants for vacancies. The Minnesota Legislature has directed HTAC to assess new and existing health care technologies, applying a Minnesota perspective. For more information, or to obtain an application, contact Mary Stadick at 612/282-6355 no later than Friday, January 24, 1997.

MMA Sets Goals for 1997 Legislative Session

When the 1997 Minnesota Legislature convenes January 7, the Minnesota Medical Association will work to achieve a number of ambitious goals aimed at preserving Minnesota's high-quality health care.

Phase Out 2 Percent Tax

The Minnesota Medical Association will make an all-out effort to convince legislators to phase out the 2 percent tax on health care revenues, beginning with a reduction to 1 percent in July 1997 and replacing the tax completely by July 1999. The current surplus of $232 million in the Health Care Access Fund is expected to grow to more than $589 million by the year 2001. This surplus will make it easier to phase out a tax that legislators originally intended to be a stopgap measure until they devised a broad-based funding strategy for the MinnesotaCare program.

For months, the MMA has been working to build support among other groups for eliminating the tax. The MMA continues to stress that it is unfair to place the burden of funding a statewide program on one segment of the population. Our message is being heard. In November, the Minnesota Health Care Commission, which represents a broad range of health care stakeholders, voted in favor of phasing out the 2 percent tax and funding the MinnesotaCare program out of the general fund. The governor, however, has not been encouraging, and there will be strong opposition from organizations that want to use the surplus in the Health Care Access Fund for purposes other than the MinnesotaCare program. A strong grassroots effort by all MMA members will be needed to replace the 2 percent health care tax.

Limit Youth Access to Tobacco

Increasing the tobacco tax is an effective way to discourage young people from starting to smoke. When Michigan passed a 50-cent per pack increase in 1994, cigarette sales dropped 30 percent within three months. The MMA will work with the Smoke-Free 2000 Coalition, the Minnesota Department of Health, and others to increase the tobacco tax by at least 10 cents per pack. A higher tobacco tax would be an appropriate replacement for the 2 percent health care tax.

The MMA will also support tougher regulations governing the sale of tobacco products, including significant penalties for selling cigarettes to minors. The MMA will continue to fight to preserve the power of local communities to pass stronger tobacco laws than the state. The tobacco companies' national strategy is to preempt local control because it's easier for them to win on the state level than the community level.

Repeal the $400 Surcharge

The MMA will work to repeal the $400 surcharge on physicians' medical licenses. Originally, this tax was

Goals continued on page 35



Viewpoint

Raymond G. Christensen, M.D.
President, Minnesota Medical Association

It's Time to Replace the 2 Percent Health Care Tax

Minnesota has historically demonstrated kind concern for its citizens. This concern allowed Minnesota to move a step closer to universal coverage by passing the HealthRight bill, which created the MinnesotaCare program. Since 1992, MinnesotaCare has helped more than 94,000 previously uninsured, low-income working people gain access to health care. The program allows people to move off welfare, accept jobs that don't include health insurance coverage, and buy MinnesotaCare insurance on a sliding scale. Moving into the work force fosters people's feelings of independence and self-worth. In addition, the reduction in the AFDC caseload will save the state an estimated $10.9 million in fiscal 1996 and $12.9 million in fiscal 1997.

Although the MinnesotaCare program appears to be a success, its funding mechanism should be reevaluated. In the early 1990s, an intense bipartisan effort by the Legislature was needed to pass the MinnesotaCare legislation and have it signed by a governor who wanted no new taxes. MinnesotaCare funding was handled obliquely to allow the bill to pass, avoid a veto, and place some of the funding responsibility on the self-insured plans, which are shielded from certain state regulations and taxes by the Employment Retirement Income Security Act (ERISA).

As you know, the MinnesotaCare program is funded by sliding-scale premiums paid by MinnesotaCare enrollees, a 2 percent tax on the revenues of hospitals and health care providers, and a 1 percent tax on HMOs and indemnity plans. Revenues for services to Medicare and Medicaid recipients are exempt from the 2 percent tax.

From the outset, the MMA argued that the 2 percent tax was an inappropriate funding mechanism for the MinnesotaCare program. It is not fair to put the burden of paying for health care for the uninsured on one segment of the population. After all, teachers aren't required to pay a special tax to fund education. Many legislators agreed an income tax would be more appropriate, but they believed the governor would veto such a proposal.

For many providers, the 2 percent tax is a direct tax on them. The "pass-through" of the tax to third-party payers was designed to shift some of the burden of supporting the MinnesotaCare program to the payers, including the self-insured plans that are protected by ERISA. Unfortunately, the pass-through does not work. Large health plans claim the tax is included in their overall payment to providers, so it is impossible to tell if they are paying the tax. Small clinics find it difficult to collect the tax, and the extra paperwork adds to their administrative expenses.

As a rural physician, I am concerned about the increasing financial instability of many small clinics that provide access to health care for patients in rural areas. The legislators who passed the MinnesotaCare legislation said that improving access to health care in rural Minnesota was one of their primary goals. But the 2 percent tax seems to be a particular burden in rural areas. Rural clinics treat a large number of Medicare, Medicaid, and MinnesotaCare patients who pay fees that are limited by the state. When the 2 percent tax is added to the limited reimbursement rates for public programs, rural physicians find it hard to make ends meet.

Like it or not, the MinnesotaCare funding mechanism clouds our ability to work effectively as patient advocates for universal coverage. Our state needs a stable, broad-based funding source, such as an income tax, that is dedicated to supporting the MinnesotaCare program. This would ensure a fair shouldering of the societal responsibility to care for the uninsured. Higher tobacco and alcohol taxes would also be appropriate because they would discourage smoking and drinking and help pay to treat illnesses or injuries caused by tobacco and alcohol.

Currently, surpluses are growing in Minnesota's General Fund, Workers' Compensation Fund, and Health Care Access Fund. This is an appropriate time for a grassroots evaluation of MinnesotaCare and for the establishment of a stable financing mechanism. It's important to have the right funding for the MinnesotaCare program. Talk to your colleagues and local community leaders. See page 33 for more information about the 2 percent tax.

I hope your holidays were happy, and I wish you the best in the New Year. Safe journeys and good health to you from the MMA.

Goals *continued from page 33*

imposed as a way to attract additional federal matching money for Minnesota's Medicaid program and it was coupled with an increase in reimbursement. But there hasn't been a reimbursement increase since 1992. Furthermore, if Congress replaces the Medicaid entitlement program with block grants to the states, the surcharge will no longer attract matching money. The MMA argues that the surcharge is an inappropriate tax on one segment of the population. The Minnesota Hospital and Healthcare Partnership will be an ally on this issue.

Repeal State Growth Limits

The MMA contends that state limits on health care spending are overregulatory, unworkable, and unenforceable. They should be repealed. Last session, the MMA initiated a bill to repeal growth limits, which won widespread support from legislators but fell victim to last-minute political maneuvering. This year, the Minnesota Department of Health intends to introduce legislation to repeal the growth limits and replace them with growth targets. The MDH draft bill is very similar to the legislation that the MMA introduced last session, and the MMA will vigorously support it.

Ban Exclusive Contracts

The MMA will propose legislation to ban exclusive contracts. Last session, the MMA pushed for a bill to extend the ban on exclusive provider contracts that expired on January 1, 1997, until the year 2000. The MMA bill passed the Senate but faltered in the House when Rep. Irv Anderson, DFL-International Falls, who was then House Speaker, refused to call the bill up for consideration. The exclusive contract ban was enacted in 1994, at MMA urging, so that health care providers could negotiate contracts with many different health plans without being pressured to sign exclusive contracts.

Oppose Chiropractors' Physical Exams

The chiropractors are expected to be back at the Legislature for the third year in a row seeking authority to perform the physical examinations that the federal government requires truck drivers to have every two years. The MMA strongly opposes legislation that would allow chiropractors to diagnose medical conditions. Minnesota law clearly states that chiropractors are only allowed to determine the presence or absence of chiropractic conditions. It does not allow diagnoses of conditions such as heart disease, diabetes, epilepsy, or sleep apnea. (See page 29.) The MMA narrowly defeated the chiropractors last session and will face a tough fight again this year. Chiropractors are a determined and politically active group. Last year, chiropractors' phone calls to legislators outnumbered those of physicians by about 30 to one. The chiropractors' ability to mobilize a grassroots effort makes them a formidable foe. MMA member involvement will be extremely important. The MMA delegation to the AMA sought help on the national level on this issue. See page 37.

Naturopaths and Others May Seek Licensure

Naturopaths plan to seek licensure at the Minnesota Legislature this session. Because of concerns that people who are not qualified are calling themselves naturopaths, they seek legislation to limit the practice of naturopathy to people who have been trained by one of three accredited schools of naturopathy in the United States. Naturopaths are trained in botanical and herbal therapies, stress management, nutrition counseling, home childbirth, and minor surgery. Minnesota naturopaths have not yet drafted a bill, however, and it is not clear how many of these activities they will try to include in their scope of practice in Minnesota. Since there are only a few naturopaths in Minnesota, they will not seek their own licensing board. They are talking to the Minnesota Board of Medical Practice about the possibility of coming under its wing. An alternative would be to approach the chiropractors. Currently, 11 states license naturopaths. In the past, the MMA has opposed licensing naturopaths, but once the bill is drafted the MMA will consider its specific language.

Other providers such as traditional (non-nurse) midwives and massage therapists are also drafting legislation. The MMA will work to make sure that licensing laws are used to protect the public from possible harm and do not have the potential to confuse or mislead people. The MMA will watch closely as the new provider bills are being developed.

Limit Use of "Physician"

The MMA intends to introduce a bill to limit the use of the term "physician" to medical doctors and doctors of osteopathy. The public should not be confused by other providers who simply wish to call themselves physicians. • • • • •

MMA Testifies on Proposed Rules for School Bus Drivers

Paul Sanders, M.D., MMA chief executive officer, testified in favor of the Minnesota Department of Public Safety's proposed rules requiring school bus driver applicants to have a thorough physical examination performed by a licensed physician. At the recommendation of the MMA, the Minnesota Department of Public Safety included in these proposed rules a clarification that the physical examination must be performed by a licensed physician. Sanders said that the MMA supports the Minnesota Department of Public Safety's conclusion that the thorough physical examinations required for school bus drivers are beyond chiropractors' statutory scope of practice.

MEDICARE NEWS

Balance Billing and Growth Limits Reminder

Since January 1996, Minnesota physicians have been prohibited from balance billing Medicare patients. The gradual phase-in of the ban on balance billing was enacted in MinnesotaCare legislation.

Minnesota's projected 1997 growth limit is 6.4 percent for providers who comply with the law through limits on growth in their revenues per patient or revenues per encounter. Because of a change in the law that took effect last year, providers who comply with the law through a limit on increases in their fee schedule are subject to a growth limit of only 3 percent, the projected 1996 regional consumer price index for urban consumers (CPI-U). The projected full growth limit for 1997 reflects the estimated 3 percent 1996 CPI-U plus a 3.4 percent X factor set by law to reflect increases in volume and intensity.

The Minnesota Department of Health will publish the actual 1996 regional CPI-U by January 31, 1997

Medicare Conversion Factors Are Announced

The conversion factors for the 1997 Medicare fee schedule are as follows:

- Primary care services 35.7671
- Surgical services 40.9603
- Non-surgical services 33.8454

Compared with the 1996 conversion factors, this represents a 2.5 percent increase for primary care services, a 1.9 percent increase for surgical services, and a 0.8 decrease for non-surgical services.

Gag Clauses Are Illegal for Medicare Plans

The U.S. Department of Health and Human Services has informed health plans that they may not limit what doctors tell Medicare patients about treatment options. DHHS is expected to issue a similar directive regarding Medicaid plans.

LEGISLATIVE NEWS

Who's Who at the Legislature?

Although the DFL/Republican balance remains nearly the same as in 1996, there will be 24 new representatives in the 1997 Minnesota House of Representatives. DFLers have a 70-64 majority in the House, one vote more than in 1996. MMA member Rep. Richard Mulder, M.D., R-Ivanhoe, kept his House seat.

In the Senate, Republicans lost one seat. There will be 42 DFLers, 24 Republicans, and one Independent in the 1997 Senate. Sen. Charles Berg of Chokio, who was a DFL senator last session, is now an Independent.

The choice of Rep. Phil Carruthers, DFL-Brooklyn Center, as House Speaker is a positive development for the MMA, according to David Renner, MMA director of policy and legislation. "We have a good working relationship with Rep. Carruthers. We look forward to working closely with him and with other leaders in both parties during the upcoming session," Renner said. Rep. Ted Winter, DFL-Fulda, is the new House Majority Leader, and Sen. Roger Moe, DFL-Erskine, remains the Majority Leader in the Senate.

On the Republican side, the leadership remains the same. Rep. Steven A. Sviggum, R-Kenyon, is the Minority Leader in the House, and Sen. Dean Johnson, R-Willmar, is the Minority Leader in the Senate.

Minnesota Senate Names Committee Chairs

Sen. Doug Johnson, DFL-Cook, will continue to chair the Senate Tax Committee. There are now three finance committees: education, state government, and human resources. Sen. Linda Berglin, DFL-Minneapolis, will chair the Human Resources Finance Committee, which will give her a stronger voice in health care budget decisions than she has had in the past. Sen. John Hottinger, DFL-Mankato, will chair the Health and Family Security Committee. Sen. Don Samuelson, DFL-Brainerd, will chair the Health and Family Security Budget Division. Sen. Sam Solon, DFL-Duluth, is once again chair of the Senate Commerce Committee. Sen. Jane Ranum, DFL-Minneapolis, is chair of the Judiciary Committee.

Minnesota House Names Committee Chairs

Rep. Dee Long, DFL-Minneapolis, is chair of the House Tax Committee; Rep. John Dorn, DFL-Mankato, is chair of the Health and Human Services Committee; Rep. Lee Greenfield, DFL-Minneapolis, remains chair of the Health and Human Services Finance Division; Rep. Wes Skoglund, DFL-Minneapolis, is chair of the Judiciary Committee; Rep. Loren Solberg, DFL-Bovey, remains chair of the Ways and Means Committee; and Rep. Irv Anderson, DFL-International Falls, is chair of the Financial Institutions and Insurance Committee.

Announcements

AMA Presents Award for MMA Stop the Media Violence Campaign

The AMA presented the President's Citation for Service to the Public in recognition of the MMA Stop the Media Violence Campaign to Raymond G. Christensen, M.D., MMA president, at the opening ceremonies of the AMA Interim Meeting of the House of Delegates. Accepting the award, Christensen said, "We must ask parents about their children's television viewing habits. We must express our outrage at the inappropriate programs and advertisements that are decaying the moral fiber of this country."

• • •

Geographic Coalition Meets

About 65 people attended the Geographic Coalition meeting, which was held in conjunction with the AMA Interim Meeting in Atlanta. The coalition reaffirmed its commitment to try to convince Congress to eliminate the vast disparities among the Medicare reimbursement rates of various states. The coalition will focus primarily on managed care reimbursement rates as Medicare tries to shift more Medicare patients into HMOs. Richard Deems of the AMA suggested strategy options for the Geographic Coalition, such as targeting the congressional representatives in counties that have low reimbursement rates. Currently, coalition dues are based on the number of members in the medical society, but the coalition may set a cap on dues to attract some of the larger states. Money is needed to develop materials that member states can use to lobby their congressional delegation. For more information about the Geographic Coalition, call Janet Silversmith at 612/378-1875 or 800/999-1875.

MMA Is Successful at AMA Interim Meeting

The Minnesota delegation to the American Medical Association introduced seven resolutions, which were favorably received at the AMA Interim Meeting, December 8 to 11 in Atlanta. The Minnesota AMA delegation, chaired by A. Stuart Hanson, M.D., included the following: Robert D. Christensen, M.D., E. Duane Engstrom, M.D., Audrey M. Nelson, M.D., Andrew J. K. Smith, M.D., Ben P. Owens, M.D., Carolyn J. McKay, M.D., Frank J. Indihar, M.D., Thomas L. Peyla, M.D., John Van Etta, M.D., and Bruce A. Norback, M.D. Audrey M. Nelson, M.D., chaired Reference Committee B, which dealt with legislative issues.

Substitute Adopted for "Exams by Chiropractors" Resolution

The AMA House of Delegates adopted the substitute resolution, "Comprehensive Physical Examinations by Appropriate Practitioners," in lieu of the Minnesota resolution, "Comprehensive Physical Examinations by Chiropractors." The substitute resolution calls on the AMA to support the position that performance of comprehensive physical examinations to diagnose medical conditions should be limited to licensed doctors of medicine or doctors of osteopathy or to those practitioners who are directly supervised by licensed MDs or DOs. It further asks the AMA to work with state medical societies and medical specialty associations, both in the courts and in the legislative and regulatory spheres, to oppose any proposed or adopted law or policy that would inappropriately expand the scope of practice of practitioners other than MDs or DOs.

The substitute resolution is broader and more inclusive than the original resolution, which asked the AMA to oppose the performance of comprehensive physical examinations by chiropractors and to develop model legislation for use by state medical associations to limit the performance of comprehensive physical examinations to licensed doctors of medicine and osteopathy. Members of the AMA Council on Legislation told the reference committee that model state legislation is not the appropriate vehicle for this policy because state practice acts are framed to establish the appropriate scope of practice of practitioners, but they do not state what such practitioners cannot do. Accordingly, the AMA decided it would be more effective to oppose the inappropriate expansion of practice acts of limited license practitioners. John Van Etta, M.D., and Robert Christensen, M.D., testified in favor of the Minnesota resolution before the reference committee.

Substitute Adopted for "Nutrition Education" Resolution

The AMA House of Delegates adopted a substitute resolution in lieu of the Minnesota resolution regarding nutrition education. The substitute resolution asks the AMA to collect data from United States medical schools on the current teaching of all aspects of nutrition and dietetics, to compare this with the content related to nutrition that is contained in Steps 1 and 2 of the United States Medical Licensing Examination, and to prepare a report with recommendations on general objectives for nutrition and dietetics education for the 1997 AMA Interim Meeting.

The original Minnesota resolution asked the AMA to encourage the National Board of Medical Examiners to ensure that all areas of nutrition and nutritionally related diseases are covered adequately on the United States Medical Licensing Examination. Testifying before the reference committee, Frank Indihar, M.D., said that nutrition and dietet-

AMA continued on page 38

AMA continued from page 37

ics education is important and should be comprehensively addressed in medical school. Other delegates pointed out that data are not available on the current extent of nutrition education or how the curriculum is related to questions on the United States Medical Licensing Examination. Some said that an examination should not be used to drive curriculum, and the AMA should not dictate curriculum. There was general agreement, however, that an analysis of existing curriculum would help medical schools identify objectives.

"Reduction of Nicotine in Tobacco" Is Referred

The AMA House of Delegates referred to the Board of Trustees a Minnesota resolution calling on the AMA to develop and support legislation that would require tobacco companies to reduce the nicotine content in tobacco products sold in the United States by incremental annual reductions so that tobacco products would be nicotine-free within six years. The resolution also asks the AMA to develop and support legislation to require tobacco companies to accurately label their products indicating nicotine content in "easily understandable and meaningful terms, which have plausible, biological significance." This proposal, developed by the Zumbro Valley Medical Society and presented to the MMA House of Delegates, received a great deal of media attention during the MMA Annual Meeting in September.

A. Stuart Hanson, M.D., who, along with Carolyn McKay, M.D., testified in favor of this resolution before the reference committee, was pleased with the AMA action. "AMA delegates viewed this resolution as an intriguing, new way to push the envelope in the fight against tobacco addiction," Hanson said, "but they felt more study was needed." The Council on Scientific Affairs will study the resolution to determine its feasibility, analyze the political process, and recommend ways to implement the resolution.

"FDA Tobacco Regulations" Is Adopted as Amended

The AMA adopted, as amended, a Minnesota resolution that calls on the AMA to strongly support, endorse as sound public health policy, and encourage the enforcement of the August 1996 Food and Drug Administration regulations to reduce children's use of tobacco. The AMA House of Delegates strengthened the resolution by adding a provision that calls on the AMA to oppose any federal legislative proposal that would weaken the proposed FDA regulations.

The FDA proposed rules include the following provisions:

- Require age-verification for all over-the-counter tobacco sales.
- Limit vending machine sales and self-service displays to places where minors are not allowed, such as certain bars and nightclubs.
- Prohibit sales of single cigarettes and packages of fewer than 20 cigarettes.
- Prohibit free samples of cigarettes.
- Ban outdoor advertising within 1,000 feet of schools and playgrounds.
- Permit black-and-white text only in tobacco advertising in publications that have significant youth readership.
- Prohibit the sale or giveaway of tobacco products, such as caps, jackets, and gym bags, that carry cigarette or smokeless tobacco product brand names or logos.
- Prohibit the brand name tobacco sponsorship of sporting or entertainment events.

The AMA also amended this resolution to include a commendation to departing FDA chief David Kessler, who has been active on tobacco issues.

Carolyn McKay, M.D., and A. Stuart Hanson, M.D., testified in favor of the FDA resolution, which is expected to reduce teenage tobacco use by 50 percent.

AMA continued on page 39

Rule Amendment Regarding X-ray Operator Examination Is Approved

• • • • • The commissioner of health has adopted amendments to Minnesota Rules regarding the x-ray operator examination, which clarify that licensed practitioners of medicine, dentistry, osteopathy, podiatry, and chiropractic do not have to meet the state's x-ray operator examination requirements in addition to their license requirements in order to operate x-ray equipment.

After January 1, 1997, x-ray operators must:

- have passed an examination approved by the commissioner of health, or
- have passed an examination determined to be equivalent to the examination approved by the commissioner such as the American Registry of Radiology Technologists examination and the American Chiropractic Registry of Radiological Technologists examination, or
- be credentialed by the licensing board of medicine, podiatry, dentistry, osteopathy, or chiropractic, or
- be taking a training course for physicians, dentists, chiropractors, podiatrists, radiological technologists, chiropractic radiological technologists, dental hygienists, or dental assistants.

For more information about the rule amendments or about the x-ray exam requirements, call Judith Ball at 612/215-0945 or Sue McClanahan at 612/215-0941.

AMA continued from page 38

"WHO Recommendations for Infant Mortality Rate" Resolution Is Referred

The AMA House of Delegates referred to the Board of Trustees a resolution asking the AMA to create a task force to work with the Center for Health Statistics and state statistics units to ensure that U.S. reporting formats incorporate World Health Organization (WHO) recommendations and are comparable to those in other developed countries so that comparisons of infant mortality rates among countries are accurate and meaningful.

McKay and Hanson told the reference committee that because the United States reporting format for the infant mortality rate is different from that of most other countries, the U.S. rate shows up as higher than it would be if another format were used. In the United States, infants weighing 500 grams or more who are born alive and later die are included in the infant mortality rate. In most other countries, however, babies must weigh at least 1,000 grams to be included in the infant mortality rate. This difference in reporting occurs because the advanced technology in the United States sometimes allows very low birthweight babies to live, and it is important to keep track of their mortality rate. But the different formats make it difficult to accurately compare rates in the United States and elsewhere. In view of the complexity of this issue, the resolution was referred to the AMA Board.

Substitute Is Adopted for "Education in Support of Animal Research" Resolution

The AMA House of Delegates adopted a substitute resolution in lieu of the Minnesota resolution calling for an expanded public education program in support of animal research.

The substitute resolution asks the AMA to expand, as a high priority, its public education program that supports the appropriate and humane use of animals in research by working with the Specialty and Service Societies in order to help SSS member organizations develop their own programs. It also asks the AMA to oppose legislative limits placed on the appropriate and humane use of animals in research. Jasper M. Daube, M.D., testified in favor of this resolution.

AMA Reaffirms "Shaken Baby" Policy

The AMA reaffirmed as existing policy the Minnesota resolution asking the AMA to seek partnerships with organizations involved in the diagnosis and prevention of shaken baby syndrome to educate and raise awareness among the public and the medical community. • • • • •

MINNESOTA NEWS

Federal Block Grant Will Force Minnesota to Make Decisions

In order to receive its federal welfare block grant of $268 million a year for six years, Minnesota must submit by July 1, 1997, a plan describing how it will implement the grant, which is called Temporary Assistance for Needy Families. At least 25 percent of all families receiving welfare benefits must work 20 hours a week. By 2002, 50 percent of families must work at least 30 hours a week. If Minnesota fails to meet these requirements it will lose some of its grant money. Approximately 5,400 legal noncitizens in Minnesota are expected to lose their eligibility for Supplemental Security Income, and the state will have to decide whether they will continue to receive Medical Assistance. The Congressional Budget Office estimates that from 1,000 to 3,000 children in Minnesota will lose SSI benefits, and about 300 to 700 children may lose their MA coverage as well. State welfare reform legislation is expected to be developed early in the 1997 session.

• • • • • • •

Minnesota Submits Phase 2 Waiver

The Minnesota Department of Human Services has submitted its Phase 2 waiver application, asking for federal authority to move forward with plans already approved by the Minnesota Legislature. These plans include a change in the look-back time for asset transfers before becoming eligible for Medical Assistance, implementation of a 30-day residency requirement to qualify for Medical Assistance, the MinnesotaCare requirement for a fee-for-service point-of-service option, and the transfer of medical education funds out of MA, GAMC, and MinnesotaCare capitation rates and into the Medical Education Research Cost (MERC) fund. The waiver application also describes the DHS's long-term goal to integrate all of the state's public assistance programs, including Medical Assistance, General Assistance Medical Care, and MinnesotaCare. A federal waiver and approval by the Minnesota Legislature would be needed before the integration plan could be implemented. The Minnesota Health Care Commission voted to support Phase 2 of Minnesota's request for a federal waiver with the exception of the request for approval of a 30-day residency requirement for eligibility in Medical Assistance.

LEGAL NEWS

High Court to Review ERISA Ruling

The U.S. Supreme Court will review the 2nd U.S. Circuit Court of Appeals ruling that clinics owned by a self-insured New York union fund, NYSA-ILA, do not have to pay the state provider tax because they are shielded from state regulations and taxes by the Employment Retirement Income Security Act (ERISA). Self-insured plans once seemed to have complete immunity from state oversight, but many believe that this shield was penetrated by the lower court decision in the Travelers case, which found that ERISA plans are subject to state laws and taxes that have only an indirect economic effect on their operations. It remains to be seen whether the Supreme Court will use the NYSA-ILA case to bring further clarity to this aspect of the law.

MMA Files Friend of Court Request

The MMA legal department has filed a request with the Minnesota Supreme Court to appear as an *amicus curiae* in a case appealing a ruling of the Workers' Compensation Court of Appeals that addresses statutory reimbursement for providing services to workers' compensation patients. The specific ruling that is being appealed injects significant confusion into reimbursement for services to workers whose claims are initially disputed but are subsequently found to be compensable under the Workers' Compensation Act. If you have any questions, call Patricia Franklin, J.D., at 612/378-1875 or 800/999-1875.

ANNOUNCEMENTS

ACCME Reaccredits MMA

The Accreditation Council for Continuing Medical Education has resurveyed the Minnesota Medical Association and has renewed its accreditation as a sponsor of continuing medical education for physicians for four years.

ACCME accreditation seeks to assure both physicians and the public that continuing medical education activities sponsored by the MMA meet the high standards of the Essentials and Standards for Accreditation as specified by the ACCME.

The ACCME rigorously evaluates the overall continuing medical education programs of institutions according to standards adopted by all seven sponsoring organizations of the ACCME. These are: the American Board of Medical Specialties, the American Hospital Association, the American Medical Association, the Association for Hospital Medical Education, the Association of American Medical Colleges, the Council of Medical Specialty Societies, and the Federation of State Medical Boards.

Public Health Proposals Are Sought

The planning committee for the 1997 Minnesota Public Health Association Annual Conference is seeking proposals from those who wish to present a concurrent session or poster presentation. The conference, "Journey to a Healthy Minnesota: Many Paths to a Common Goal," will be held April 24 to 25, 1997, at the Minnesota Landscape Arboretum in Chanhassen. The planning committee seeks proposals that demonstrate successful partnerships between research and practice and/or public/private/nonprofit sectors in rural and urban areas. For further information call Kim Miner, MDH, 612/623-5334, or Becky Siiteri, UCare, 612/603-5363.

Nonprofits Must Register

Nonprofit corporations are required to file a simple registration statement with the Office of the Secretary of State once each calendar year. To determine if a nonprofit corporation has filed the necessary registration or to obtain a registration form, call 612/296-2803. Once a nonprofit has filed, a registration form will be mailed to the address of record once each year as a reminder of the requirement. Nonprofit corporations that do not file an annual registration will be dissolved and their corporate status ended.

The Monitor
JANUARY 1997

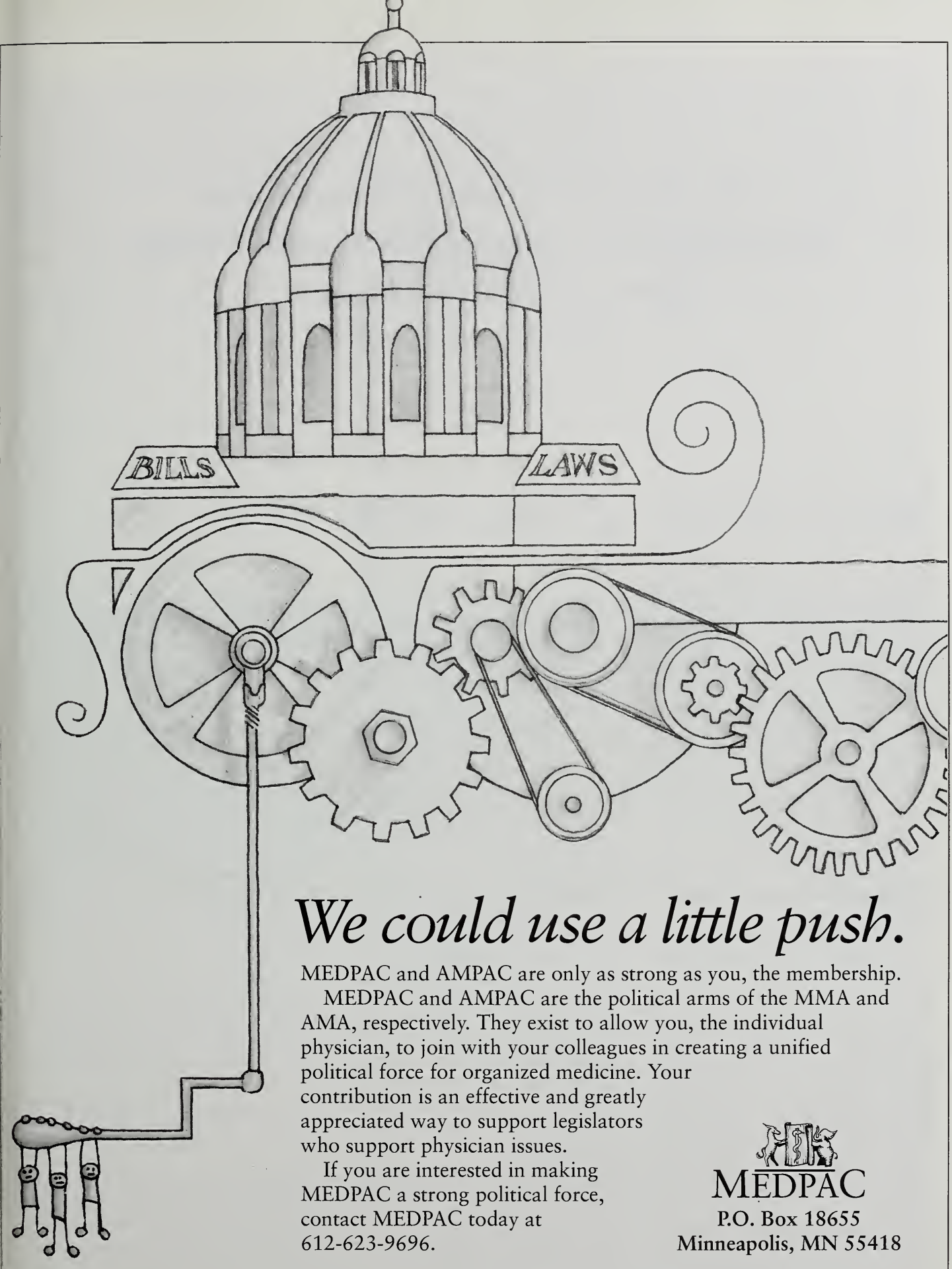
President
Raymond G. Christensen, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Director, Communications
Mark S. Vukelich

Editor
Lorrie Holmgren



We could use a little push.

MEDPAC and AMPAC are only as strong as you, the membership.

MEDPAC and AMPAC are the political arms of the MMA and AMA, respectively. They exist to allow you, the individual physician, to join with your colleagues in creating a unified political force for organized medicine. Your contribution is an effective and greatly appreciated way to support legislators who support physician issues.

If you are interested in making MEDPAC a strong political force, contact MEDPAC today at 612-623-9696.

MEDPAC
P.O. Box 18655
Minneapolis, MN 55418

MEDPAC is a bipartisan organization endorsed by the Minnesota Medical Association and affiliated with AMPAC, an organization established by the American Medical Association. MEDPAC and AMPAC contributions should be written on personal checks. Funds from corporations or incorporated practices cannot be accepted for MEDPAC's political contribution fund: corporate checks will be accepted for non-election activities. Contributions are not limited to the suggested amount. Neither MMA nor AMA will favor or disadvantage anyone based on the amounts or failure to make PAC contributions. Voluntary political contributions are subject to prohibitions and limitations of FEC regulations (federal regulations require this notice). Contributions to MEDPAC or AMPAC are not deductible as charitable contributions for federal income tax purposes.

Do State Licensing Procedures Discriminate Against Physicians Using Mental Health Services?

One physician calls for reform.

Steven Miles, M.D.

My experience with the Minnesota Board of Medical Practice (BMP) since disclosing on my license renewal application that I have used mental health services has led me to believe that the board's procedures need fundamental reform. Its procedures for deciding whether to renew physicians' licenses are poorly grounded, counterproductive, overly invasive, and potentially illegal. The 1996 medical license renewal form asked physicians to disclose various physical and mental conditions. The form also queried physicians about disciplinary actions, civil lawsuits, and criminal charges. The BMP can use such information to bar physicians from practice or require that they be retrained or supervised.

The 1996 renewal form clearly differentiated between physiological and mental conditions. Questions about an applicant's physiological diseases inquired whether they caused occupational disability. For example, question 1 read: "Since your last renewal, did you have any physiological disorder or conditions which impaired your cognitive, communicative or physical capability to engage in the practice of medicine with reasonable skill and safety?" By contrast, three of the four questions about mental conditions (4, 6, and 8) focused on the diagnosis or treatment of mental illness rather than on disability. These questions ask whether physicians have been diagnosed with or have been treated for bipolar disorder, schizophrenia, paranoia, any other psychotic disorder; pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders; or compulsive gambling or kleptomania.

Minnesota law does not say that the BMP must or should investigate any or all physicians who have been diagnosed with or treated for mental illness. Even so, the BMP's procedure is to initiate an investigation, the first step in what it calls a disciplinary action against physicians who disclose the diagnosis or treatment of mental illness without corroborating evidence of disability such as complaints, malpractice actions, or criminal activity.

In order for the BMP to investigate a physician, it must have "probable cause"[1] to believe that the physician has the "inability to practice medicine ... [as] a result of any mental or physical condition."[2] As I interpret Minnesota law, once the BMP finds "probable cause" for an investigation, the physician is presumed disabled and bears the "burden of proof ... to demonstrate his or her qualifications."[3] A physician must also cooperate with the investigation.[4] "Failure ... to submit to a mental examination or to supply medical records constitutes an admission of the allegations (sic) against the person."[1] Thus, the self-disclosure of diagnosis or treatment allows the BMP to presume the physician is disabled, which the physician must then disprove.

Case

I have type II bipolar disorder, a mainly depressive disorder with nondisabling periods of hypomania that are helpful diagnostically and that point to highly effective therapy. I have been, and am, successfully treated. I have disclosed this condition to my employers, and I pursue a successful and productive career in academic and clinical internal geriatric medicine. I have not been disciplined or sued, and no complaints have been filed regarding my professional conduct. I have noted my experience in the *Journal of the American Medical Association*. I have urged other physicians to use mental health services, discussing the issue with a large group of medical students the day after one of their classmates committed suicide.

I answered the license renewal questions honestly. On that basis, the BMP demanded copies of all notes and records from my treating physician. The BMP did not disclose that it was engaged in an investigation or that it presumed disability. Letters from the BMP merely stated that it was "required by law to assess this information." The BMP has never confirmed that I am part of an investigation or identified the statutes upon which their requests were based. I discussed the BMP's request with my physician, with mental health professional groups, and an attorney, and I reviewed the medical literature and Minnesota statutes. As a result,

I believe that the BMP's procedures probably:

- went beyond the requirements of Minnesota law by requesting additional information regarding my mental condition as a result of my disclosure;
- violated confidentiality of medical records; and
- violated the Americans with Disabilities Act (ADA).

My lawyer and I have submitted to the BMP material from the American Psychiatric Association (APA), the state chapter of the APA, legal cases, professional literature, and the name of a lawyer with the U.S. Department of Justice who has written legal briefs arguing that procedures similar to the BMP's violate the ADA. The BMP's attorney defended its policy (see the following discussion) and said the investigation would continue. As this article goes to press 11 months after completing my license renewal form, I have accumulated $8,000 in legal fees and am awaiting the BMP's next step.

Five Problems With the BMP's Position on Mental Illness

I see five problems with the BMP's position on mental illness. First, the distinction between physiological conditions or disorders and mental illnesses does not comport with modern understandings of neuropsychiatry.

Second, the BMP's finding of "probable cause" or presumed disability based on diagnosis or treatment alone is discriminatory and unsupported. In a letter to my attorney dated May 10, 1996, Sarah Mulligan, assistant attorney general and counsel to the BMP, argued in support of the BMP's policy. She wrote: "The [mental] diagnoses listed can be extremely disabling illnesses and can greatly impair the ability to practice a profession. They are known to be chronic. And sufferers' insight into the illness and ability to cooperate with treatment vary, thus requiring an assessment of the individual's history of the disease as well as present manifestations."

The licensing renewal form suggests that physicians with "physical" illness have the insight to limit their practice for self-perceived disability. The form implies that physicians who use mental health services do not have this ability, a position that is

Excerpts from American Psychiatric Association Confidentiality Statement*

It has been proposed that physicians have a special duty to the public which can only be discharged by requiring that the physician's own health record pertaining to the physician's mental health be exposed to the scrutiny of those who oversee the fitness of individuals to practice medicine.

No convincing argument has been advanced to show that a patient should be deprived of the right to the privacy of his or her medical record simply because he or she has chosen to study or practice medicine. We believe that reasonable protection of patients does not require the assumption that anyone who is now, or has been, a psychiatric patient is potentially so harmful to patients that he or she cannot practice medicine without presenting his or her otherwise private medical record for public scrutiny. There is no evidence to suggest that the hazard is so great that normal safeguards are inadequate.

Moreover, there is a greater danger that individuals needing treatment will be barred from obtaining professional help if getting it would require them to bare their innermost secrets to public or private overseers. More likely, they would try to conceal the need and continue to practice without treatments for what might be curable ills. Far from protecting the public, it is likely that the abolition of the confidentiality of the physician's personal health records would simply discourage troubled people, many with treatable disorders, from finding appropriate medical help and would hamper those trying to help them. We believe that such an impaired individual is far more likely to endanger patients than would be the case if medical treatment were less a private matter for medical professionals than it is for others.

Licensure boards seeking to know whether a history of psychiatric disorder impairs present function should do so on a case-by-case basis and only for cause. The mandatory disclosure of the physician's confidential medical or personal history is without merit. The supposedly heightened protections for patients sought by those who would exclude physicians from the traditional safeguards of medical confidentiality are illusions.

*Position statement of confidentiality of medical records: does the physician have a right to privacy concerning his or her own medical records? Am J Psychiatr 1984;141:331-2.

Protecting Physicians and the Public Interest

A representative of the Minnesota Psychiatric Society argues that impairment, not diagnosis, should be the focus of Board of Medical Practice questions.

Richard D. Lentz, M.D.

The Minnesota Psychiatric Society (MPS) is very concerned about the nature of the questions the Board of Medical Practice (BMP) asks when physicians renew their medical licenses or apply for new licenses. A task force is actively studying the issue, but a formal statement is not yet available. The MPS hopes to work with the BMP to modify the questions so that they address impairment, not diagnosis.

As chair of the Minnesota Psychiatric Society's Committee on Board of Medical Practice Relationships, I would like to address seven pertinent issues related to mood and some psychotic disorders.

1. Bipolar mood disorders are far more common than previously believed and have many presentations. Like major depressive episodes, upswings may vary from extremely mild to severe. One form, bipolar mood disorder, Type II, has brief, usually mild hypomanic, along with depressive, episodes.

2. Significant major depressive episodes occur in 10 percent to 15 percent of the entire population (including physicians), and up to 20 percent of these episodes have some psychotic components. Hence, perhaps 2 percent to 3 percent of all people, including physicians, might have experienced at least mild transient psychotic features.

3. Almost all physicians with these common mood disorders, even when severe, seek treatment appropriately, take sick leave as needed, never endanger their patients, and, therefore, are never "impaired."

4. Many medical problems such as high fever, toxic responses to medication, and transient severe organ system problems are associated with completely reversible delirium with psychotic features; however, BMP questions don't exclude these problems.

5. Current BMP questions perpetuate the myth that mental illness is equivalent to impairment, a stigma that prevents many people from seeking help. The U.S. Public Health Service is vigorously working to destroy this kind of stigma involving mental illness.

6. I assume the BMP has encountered the rare situation where a physician with psychiatric illness does become transiently impaired in practice. Questions about impairment, not diagnosis, would address such a situation.

7. Physicians should be encouraged to seek help for psychiatric disorders. Without a reasonable guarantee of privacy, many physicians, like pilots, politicians, and others who fear stigma or loss of their livelihood, will not do so. The risk of physician impairment only increases. Just as the public interest is served by protecting the privacy of quality assurance activities and peer review within medical practices and institutions, protecting the privacy of physicians seeking medical help will improve the quality of medicine.

The BMP plays a vital role in protecting the public from a physician who may be impaired. I personally endorse that role. I also believe that a policy that encourages physicians to seek help best serves the public interest. Such a policy is essential to the safe practice of medicine and is compatible with a modern understanding of mental illness. Questions that focus on psychiatric diagnosis, rather than impairment, only discourage physicians from seeking the very help they need.

Richard Lentz is chair of the Minnesota Psychiatric Society's Committee on Board of Medical Practice Relationships, consultant in psychiatry at Park Nicollet Clinic-Health System Minnesota, staff member of the Professional Assessment Program at Abbott Northwestern Hospital, and clinical professor of psychiatry at the University of Minnesota.

reaffirmed in the letter from Mulligan. The BMP has not offered empirical support that surgeons with Parkinson disease, for example, or family practitioners with open infected sores on their hands who do obstetric procedures have greater insight into their potential disability or danger to patients than a physician who has sought out, worked with, and been successfully treated by a psychotherapist.

Third, the BMP's list of mental health diagnoses that deserve scrutiny for presumptive disability is arbitrary. Why do kleptomania or compulsive gambling merit special inquiry for occupational disability, while the relicensing form is silent on post-traumatic stress disorder and multiple personality disorder?

Fourth, the BMP's request to independently review physicians' mental health records is both needlessly invasive and unlikely to be a useful remedy for, as Mulligan alleges, physicians' varying "insight into [their] illness and ability to cooperate with treatment." It is needlessly invasive in that the privacy of mental health records is violated to allow discussion by board members, some of whom are not qualified to render an opinion on mental health. A review of mental health records by a board culling often sketchy raw data from another practitioner's chart notes is less likely to lead to a sound psychiatric opinion than a review rendered by an independent qualified mental health professional following up on tangible evidence of occupational disability.

Fifth, mental health experts have concluded that presuming disability based on diagnosis alone and requiring a surrender and review of mental health records is counterproductive to the goal of assuring maximum mental health of health professionals (see the accompanying sidebars on pages 43 and 44).

The Americans with Disabilities Act

The Americans with Disabilities Act (ADA) bars imposing discriminatory burdens on persons who are disabled or on persons who are wrongly perceived to be disabled.[5] Courts agree that the ADA applies to licensing board procedures.[6] A New Jersey court, for example, decided that the ADA applied to the state medical licensing board and that a class action against the board was permitted.[7] Before the case went to trial, the New Jersey board rescinded questions and procedures that relate to mental illness. *Minnesota Medicine* discussed the Minnesota Board of Medical Practice's procedures in light of the ADA in 1994 (see "Are Medical Licensing Questions Discriminatory? May 1994, page 27; an update to that article appears this month on page 47).

I believe that the following three elements of the BMP's policies and practices violate the ADA:

1) The BMP operates under the assumption that mental conditions fundamentally differ from physiological conditions;

2) This difference alone constitutes "probable cause" to presume medical disability without supporting evidence of disability; and

3) The BMP imposes extra procedural burdens and invasion of privacy on physicians with mental health conditions.

A key issue for an ADA ruling is whether the imposed discriminatory burden is a loss of privacy or the discriminatory loss of practice privileges. Minnesota's attorney general cites a Texas case that found no ADA violation because the physician had virtually no chance of losing the opportunity to practice.[8] However, other courts have supported ADA claims, and the implicit view of the American Psychiatric Association is that the loss of privacy is discriminatory[9, 10] (see the sidebar, page 43). Another court focused on a board's lack of empirical evidence supporting the effectiveness of the inquiries and presumed disability.[11]

This past summer, the U.S. Supreme Court rejected balancing confidentiality of mental health care records with state interests—the centerpiece of the BMP's procedures. The court ruled: "Effective psychotherapy depends on confidence and trust and therefore the mere possibility of disclosure of confidential communications may impede the development of the relationship for successful treatment. The privilege also serves the public interest since the mental health of the Nation's citizenry ... is a public good of transcendent importance. ... Making the promise of confidentiality contingent upon a ... later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privacy. ... An uncertain privilege is little better than no privilege at all."[12]

In my opinion, this ruling arguably bars the Minnesota Board of Medical Practice from demanding medical records as a part of any mental health investigation.

Conclusion

The BMP provides Minnesotans protection from disabled physicians, but so do criminal proceedings, malpractice actions, peer review, and supervisory relationships. As the American Psychiatric Association and the Supreme Court point out, the destigmatization of and unthreatened access to mental health care also substantially protect the public from persons with mental illnesses, including physicians. I believe that promoting access to mental health care—without fear that such care will trigger a disciplinary investigation—protects patients at least as well as spotty board oversight of physicians who are willing to admit receiving mental health care.

The BMP's procedures must conform to state and federal law, constitutional principles, legal precedents, and to due process. I believe the BMP should retract its request for my medical records, or at least explain why it has not done so, given the Supreme Court ruling apparently bearing on the legality of that request.

The BMP's letters did not inform me that it was engaged in an investigation, of the statutory basis of the investigation, or that the investigation presumed that I was disabled. The BMP did not even provide this information in response to a written request. This lack of communication and due process (less than that printed on parking tickets) is unaccept-

able in collegial or professional relationships. It misleads and intimidates physicians who are trying to properly respond to the BMP's inquiries. Physicians who are in similar situations, who have been asked to surrender medical or psychiatric records, or who have been sanctioned or burdened on the basis of information about their medical conditions or treatment alone, should consider seeking redress.

The Minnesota Board of Medical Practice's procedures merit a challenge. The goal of such a test would be to improve the access to and climate for mental health care for every physician. That goal is in every Minnesotan's interest. MM

Steven Miles is an associate professor of medicine in the Department of Geriatrics at St. Paul-Ramsey Medical Center and the University of Minnesota and associate faculty at the University of Minnesota Center for Biomedical Ethics.

REFERENCES

1. Minn. Stat. § 147.091, Subd. 6 (a) (b) (1996).
2. Minn. Stat. § 147.091, Subd. 1 (l) (1996).
3. Minn. Stat. § 147.091, Subd. 1 (a) (1996).
4. Minn. Stat. § 147.131 (1996).
5. Pub L. No. 101-336 (42 U.S.C. § 12134).
6. Coleman P, Shellow R. Ask about conduct, not mental illness: a proposal for bar examiners and medical boards to comply with the ADA and Constitution. J Legislation 1994;20(2):147-77.
7. Medical Soc'y of N.J. v. Jacobs, No. 93-3670, 1993 WL 413016 (D.N.J.)
8. Applicants v. Tex. State Bd. of Law, No. A 93 CA 740 SS, 1994 WL 776693 (W.D. Tex.).
9. Ellen S v. Fla. Bd. of Bar Examiners, 859 F. Supp. 1489 (S.D. Fla. 1994).
10. Underwood for Admission to the Bar of the State of Me., 1993 WL 649283 (Me.).
11. Clark v. Va. Bd. of Bar Examiners, 880 F. Supp. 430 (E.D. Va. 1995).
12. Jaffee for Allen deceased v. Redmun, 116 S.C. 1923 (1996).

The Perfect Fit...

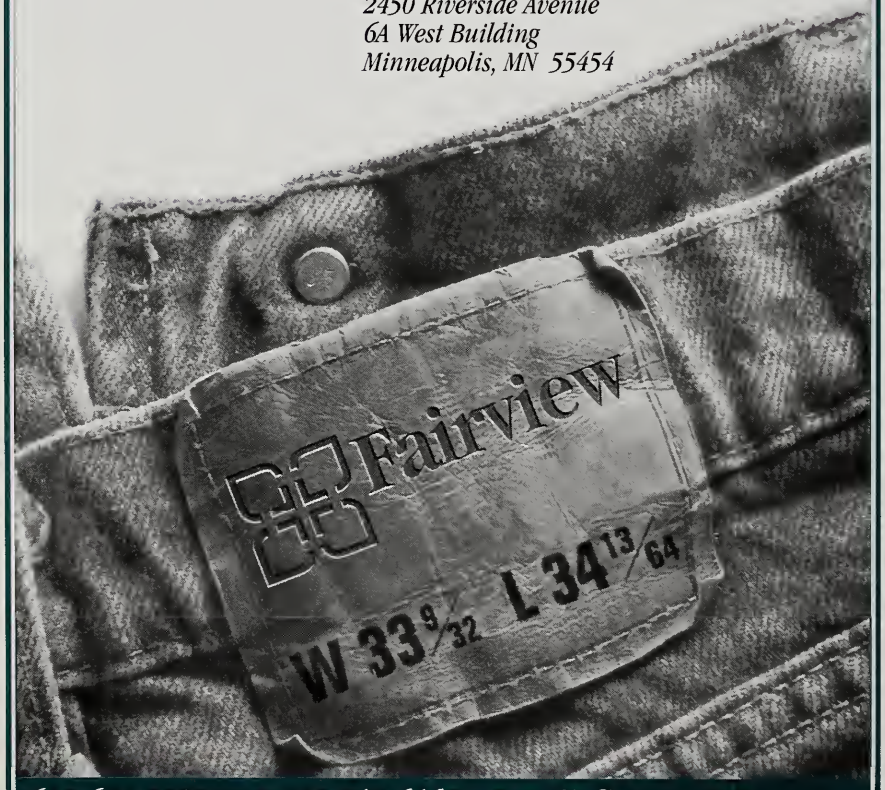
...is a rare find. Fairview Health System represents a wide spectrum of practice and lifestyle options in Minnesota. We will help you locate opportunities that are tailored to fit your needs in communities that match your size.

Opportunities now available in communities large, medium and small (and sizes in between) for...

- **Endocrinology**
- **Family Practice**
- **General Surgery**
- **Internal Medicine**
- **Obstetrics/Gynecology**
- **Orthopedic Surgery**
- **Urgent Care**
- **Urology**

Fairview

Physician Recruitment & Retention Dept.
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454



612-672-2288 or 1-800-842-6469 • E-mail: fhsrecruit@aol.com

The Impact of the Americans with Disabilities Act on Medical Licensing and Credentialing

Recognizing its obligations under the ADA, the Minnesota Board of Medical Practice has modified licensing application questions, and entities credentialing physicians may similarly analyze their questions.

Margo S. Struthers, J.D., and Melissa Raphan, J.D.

Health care entities that grant participation status or privileges to independent physicians are increasingly being held to the standards established by the Americans with Disabilities Act (ADA), as are state medical licensing boards in posing questions on physician licensing applications. This article explores the effect of the ADA on both medical licensing and credentialing.

Applicability of the ADA to Health Care Entities

Although the ADA is commonly understood to apply in employment relationships, courts also recognize claims by independent physicians against health care institutions under Title II (public services) and Title III (public accommodation) of the ADA. Title II applies to entities that are either owned by or that serve as instruments of state or local government. It prohibits such a public entity from excluding any "qualified individual with a disability" from benefits of the services, programs, or activities of the public entity, or from subjecting that individual to discrimination.[1]

In contrast, Title III of the ADA applies to privately owned entities that are considered public accommodations, which include the professional offices of health care providers and hospitals.[2] Similar to Title II, Title III prohibits discrimination against any individual on the basis of disability in the "full and equal enjoyment of the goods, services, facilities, privileges, advantages or accommodations of any place of public accommodation."[3]

Medical Licensing Boards

State medical licensing boards have faced scrutiny under Title II of the ADA relating to the questions they ask on physician licensing applications. In New Jersey's U.S. District Court, the Medical Society of New Jersey claimed that the following questions on medical licensing applications and renewal applications unlawfully inquired into the existence of disabilities and that licensing decisions based on affirmative answers constituted disability discrimination and violated the ADA:[4]

- Have you ever been dependent on alcohol or controlled dangerous substances?
- Have you ever been treated for alcohol or drug abuse?
- Have you ever suffered or been treated for any mental illness or psychiatric problems?
- Do you have any uncorrected physical handicap that causes substantial impairment of, or limitation on, your ability to practice medicine and surgery?

Physicians who answered affirmatively to any of these questions, and similar questions on the renewal application, were required to submit a summary of diagnosis, treatment, and prognosis to the New Jersey Board of Medical Examiners.

The court prohibited the board from compelling physicians to answer such questions and subsequently awarded the Medical Society of New Jersey its attorney fees. The parties ultimately settled the matter by agreeing that the State Board of Medical Examiners would no longer ask the challenged questions and that any previous answers to those questions would not be used for any purpose. In addition, the Medical Society of New Jersey agreed that it would not challenge the following more limited set of questions if posed on medical licensing and renewal applications:

- Do you have a medical condition which in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
- Does your use of chemical substance(s) in any way impair or limit your ability to practice medicine with reasonable skill and safety?
- Are the limitations or impairments caused by your medical condition reduced or ameliorated because you receive ongoing treatment (with or without medications) or participate in a monitoring program? If yes, please explain.
- Are the limitations or impairments caused by your medical condition reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice? If yes, please explain.
- Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism

or voyeurism? If yes, please explain.

• Are you currently engaged in the illegal use of controlled dangerous substances?

• If yes, are you currently participating in a supervised rehabilitation program or professional assistance program which monitors you in order to assure that you are not engaging in the illegal use of controlled dangerous substances? If yes, please explain.

These court-approved revised questions were more narrowly tailored and fall into three broad categories: 1) questions that ask whether physicians have any condition that will affect their ability to perform their job; 2) questions that focus on current illegal drug use (not protected under the ADA); and 3) questions that ask about diagnosis for conditions specifically excluded from ADA protection (e.g., pedophilia, exhibitionism, or voyeurism). The questions that the court approved do not violate the ADA either because they are permissible inquiries under the ADA or they seek information about conditions not protected by the ADA.

Minnesota's response

Recently, the Minnesota Board of Medical Practice (BMP) revised a number of questions on its initial and renewal applications to practice medicine. Like the New Jersey board, the BMP more narrowly worded its questions. Many questions now inquire whether the physician's ability to practice medicine is in any way impaired, thereby focusing the inquiry on the physician's ability or inability to perform the job, not on a protected disability or disorder. For example, on the renewal application, instead of inquiring about specific disorders and conditions that impaired a physician's abilities since his or her last renewal, the BMP revised the question as follows:

• Since your last renewal, has your cognitive, communicative, or physical ability to engage in the practice of medicine or surgery with reasonable skill and safety been impaired or limited in any way?

Follow-up questions ask whether the limitations or impairments are ameliorated by ongoing treatment or monitoring, or by the field of practice, the setting, or the manner of practice.

Other questions ask about diagnoses or treatment for pedophilia, exhibitionism, voyeurism, or other sexual behavior disorders, and compulsive gambling or kleptomania. In addition, the BMP revised its relatively broad inquiries into physician use of drugs, alcohol, and mood-altering substances. The revised questions focus on the use of illegal controlled substances and follow-up treatment:

• Since your last renewal, have you engaged in any illegal use of controlled substances including use of illegal controlled substances (e.g., heroin, cocaine) or illegal use of legal controlled substances (i.e., not obtained pursuant to a valid prescription of a licensed health care provider)? Please describe.

• Have you taken any steps (i.e., treatment, psychotherapy, participation in a support group) to discontinue or reduce such use? Please describe.

• Are you now participating in a supervised rehabilitation program or professional assistance program which has as a component a monitoring regimen designed to assure that you are not currently engaging in the use of illegal controlled substances? Please describe.

The question that focuses on alcohol and other chemicals now reads:

• Since your last renewal, has your use of alcohol or chemical substance(s), including prescription medications, in any way impaired or limited your ability to practice medicine with reasonable skill and safety? Please describe.

Another question asks about DWI charges or other impaired driving offenses involving alcohol or other chemicals.

The BMP's revised questions are not as limited as those used by the New Jersey State Board of Medical Examiners. For example, while the BMP's first revised question asks if the physician's ability to practice medicine with reasonable skill or safety is limited in any way, one of the follow-up questions does not contain qualifying language that ties the condition to the ability to practice medicine with reasonable skill or safety. This question asks:

• Since your last renewal, have you been diagnosed with or have you been treated for bipolar disorder, schizophrenia, paranoia, or other psychotic disorders? Please describe.

The ADA allows questions about current or recent illegal drug use and questions about whether the use of alcohol or chemical substances impacts the physician's ability to practice medicine with reasonable skill and safety. Only the future will tell whether questions asking physicians to self-disclose conditions that may be considered disabilities under the ADA—questions that do not include the qualifying language "affects the physician's ability to practice medicine with reasonable skill and safety"—will withstand challenge. However, the revised questions indicate licensing boards are increasingly aware of the limits on permissible inquiries under the ADA.

Entities Granting Practice Privileges

Health care entities credentialing physicians potentially face both the limitations on what can be asked under the ADA and the risks of liability to injured persons if an incompetent physician is allowed to practice at a health care facility or as part of a provider network.

In a recent case, a hospital revoked the privileges of a neurosurgeon with a history of alcoholism and required that he get a second opinion regarding his condition and the likelihood of relapse before the hospital would reinstate the physician's staff privileges. The neurosurgeon refused to undergo the evaluation and sued the hospital for violating his rights under the ADA.[5] The hospital argued that the ADA did not apply because it was not the physician's employer.

Although the court ultimately dismissed the suit, it rejected the argument that the ADA did not apply because the plaintiff had filed his claim under Titles II and III, which do not require an employment relationship as a prerequisite. In the end, the court dismissed the neurosurgeon's

Title III claim because the hospital, as a publicly owned entity, was specifically excluded from coverage under Title III, which only applies to private entities. However, the court did rule that Title II covered the hospital's conduct in processing the physician's application for staff privileges.

The court ultimately held that the hospital had legitimate public health and safety concerns for requiring a neurosurgeon who was a recovering alcoholic to undergo a second, specialized medical evaluation before reinstating his staff privileges.* In reaching its decision, the court noted that the hospital's requirement rested not on generalized fears about those suffering from alcoholism but on the "uncertain past history, and reasonable judgments of a specialized medical professional."[6] Presumably, the court was recognizing the hospital's potential liability for negligent credentialing if it did not adequately inquire into the neurosurgeon's ability to perform procedures with reasonable skill and safety.†

EEOC OFFERS INTERPRETIVE GUIDELINES

The Equal Employment Opportunity Commission (EEOC) has issued guidelines for preemployment inquiries that may help analyze whether medical credentialing questions violate the ADA.[7] The guidelines state that an employer may not ask disability-related questions and may not conduct medical examinations until *after* the employer makes a conditional offer of employment to the applicant. The ADA prohibits questions that directly elicit or are likely to elicit information about a disability. For example, the guidelines indicate that employers may *not* ask an applicant at the preoffer stage how many sick days the applicant used within the past year, because the question relates directly to the severity of the applicant's impairment.

Once a conditional job offer is made, however, the guidelines allow an employer to ask disability-related questions and to require medical evaluations, provided the same procedures are followed for all employees entering that job category. If the questions or examination screens out an individual because of a disability, the employer must demonstrate that the rejection is "job-related" and "consistent with business necessity."[7]

In light of recent case law, health care entities might consider adhering to similar standards in posing questions to physicians for credentialing purposes. These entities would be wise to avoid asking questions that directly relate to a disability or are likely to elicit information relating to a disability until after they have made a conditional credentialing offer.

CONCLUSION

Health care entities and medical licensing boards must carefully consider whether they have obligations under the ADA and, if they do, how to obtain information needed to protect health care consumers without violating the rights of physicians. Health care entities and medical licensing boards must avoid asking questions that may elicit information about an applicant's disability. At the same time, they must solicit sufficient information to determine whether the applicant is competent to practice medicine. Further development of the law and a public policy debate may be necessary before we reach an appropriate balance. MM

ACKNOWLEDGMENT

The authors wish to express their appreciation to Oppenheimer Wolff & Donnelly associate Christine Kucera, who assisted in the preparation of this article.

Margo Struthers is a partner in the law firm of Oppenheimer Wolff & Donnelly in Minneapolis. Melissa Raphan is a partner at Dorsey & Whitney in Minneapolis.

This article is a general discussion of legal issues and is not intended as legal advice. The general principles discussed here may not apply to a specific legal problem. This article is no substitute for the advice of knowledgeable legal counsel who has reviewed the specific facts and law regarding any given legal matter.

REFERENCES

1. 42 U.S.C. § 12131(1) and § 12132.
2. 42 U.S.C. § 12181(6) and (7).
3. 42 U.S.C. § 12182.
4. Medical Soc'y of N.J. v. Jacobs, No. 93-3670, 1993 WL 413016 (D.N.J. October 5, 1993).
5. Judice v. Hospital Serv. Dist. No. 1, 919 F. Supp. 978 (E.D. La. 1996).
6. Judice v. Hospital Serv. Dist. No. 1, 919 F. Supp. 978, 984 (E.D. La. 1996).
7. ADA Division of the Office of Legal Counsel. EEOC: enforcement guidance on pre-employment inquiries under the Americans With Disabilities Act. In: The Bureau of National Affairs fair employment practices manual. Washington, D.C.: Bureau of National Affairs, 10 October 1995.

*The ADA allows public entities to apply different conditions and criteria if necessary for their safe operation. As a result, courts are being placed in the position of balancing the health care entity's concerns for public health and safety with the legal obligation to not discriminate against the physician.

†If a health care institution fails to conduct a detailed inquiry into whether a physician is competent, a patient injured by the allegedly negligent conduct of that physician could file a negligent credentialing claim. In such cases, the patient typically sues both the physician for medical malpractice and the health care institution for negligent credentialing, alleging that the health care institution should not have extended privileges to the physician in light of the physician's incompetence. *See* Corrigan v. Methodist Hosp., 869 F. Supp. 1208 (E.D. Pa. 1994).

An Environmental Thriller

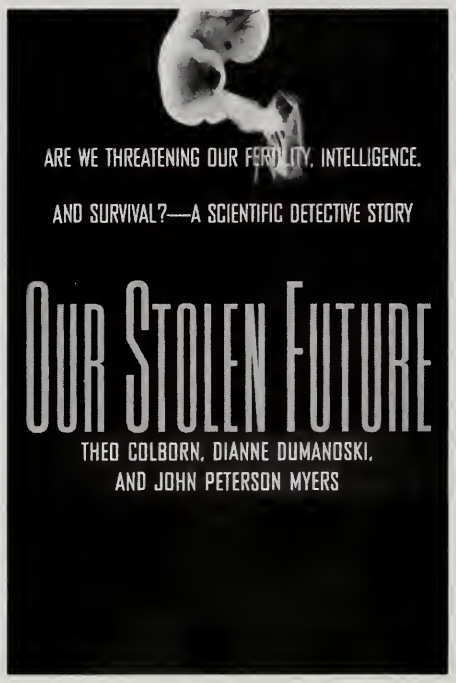
"Our Stolen Future" (Dutton, 1996) forecasts deformed offspring and mass sterility, but does the warning have scientific foundation?

Charles R. Meyer, M.D.

"Fish Hormone Problems Linked to Toxins"

–Los Angeles Times
November 19, 1996

It's a scary world out there. Each week brings a new threat from something we thought was safe. Power lines, saccharin, nitrates, milk, eggs, hamburger, aspartame. As the risks multiply, a paranoid world worthy of a Robert Ludlum novel emerges. The intricacies of science and garbled media translation make it tough for the public to evaluate these environmental hazards. Medical science ought to help, but scientific proof seems scant in environmental medicine and alarming reports keep coming. A toxin tocsin is sounded in the book "Our Stolen Future," billed by its authors as a "scientific detective story."



Two of the authors, Theo Colborn and John Peterson Myers, are environmental scientists with Ph.D.s in zoology who play key roles in this saga of PCBs, DDT, and infertility. The third author, Dianne Dumanoski, is a science writer for the *Boston Globe*. The story's villains are environmental toxins that mimic or interfere with the actions of hormones. Accessories to the crime are government and the scientific establishment, both of whom ignore the threat. The victims are diverse mammals—from dolphins to polar bears to humans.

Here's the plot summary: In recent years, hundreds of synthetic chemical "hormone impostors" have been released into the environment. Laboratory and real-life evidence shows that these chemicals interfere with the normal hormonal function of mammals. Proof of this interference includes a fall in fertility and a rise in cancer frequency. The authors predict a gloomy future of deformed offspring and mass sterility orchestrated by these chemicals, which have insinuated themselves into mammalian systems. This late-night thriller stuff is guaranteed to send you straight to your friendly organic grocer.

Does this thriller have scientific foundation? The authors do provide convincing documentation of the detrimental effects of estrogen mimics like DDT, PCBs, and dioxin in animal populations. Laboratory evidence comes from feeding animals large doses of these substances over a period of time and observing soaring sterility, misdirected reproductive development, and blossoming cancers. This evidence is further complemented by experiments of nature. The authors describe abnormalities in the arctic polar bear and high concentrations of PCBs in bear adipose tissue. They also trace the fascinating odyssey of a PCB molecule from American industrial effluent to seals on Baffin Island.

Yet the thesis falters when extrapolated to humans. The authors try to support their claim with three lines of evidence. They point to proven toxic effects in humans from hormone disrupters like thalidomide. They note that humans share a position at the top of the food chain like many of the mammals that have been affected and conclude, "What is happening to the animals in Florida, English rivers, the Baltic, the high Arctic, the Great Lakes, and Lake Baikal in Siberia has immediate relevance to humans." They contend that clusters of non-Hodgkin lymphoma and sarcomas following the Times Beach, Missouri, and Serveso, Italy, dioxin exposures bolster their hypothesis.

The skeptical scientist hollers, "Whoa! Give me cause tightly linked to effect!" To this, the authors reply: "Because the endocrine disruption question has surfaced so recently, the

scientific case on the extent of the threat is still far from complete. Nevertheless, if one looks broadly at a wide array of existing studies from various branches of science and medicine, the weight of the evidence indicates that humans are in jeopardy and are perhaps already affected in major ways." Yet what follows is lightweight reports of pediatricians describing increased frequency of genital abnormalities in children and weak links between toxins and the rising incidence of breast and prostate cancer. The authors mention but minimize the role of improved detection in the increased cancer rates.

This book capsulizes the frustration of wrestling with environmental medicine. Conditioned to fear the unnatural despoiling of our world, we look for scientific guidance about what to avoid or what to ban. We are met with suggestive animal data, partially pertinent human incidents, and spooky disease groupings. We have to deal with parts-per-trillion chemical levels and decade-long disease latency. And we have to buy the "rats are human" argument. Yet how big will the disaster be if we ignore a real problem? Do we wait for a graphic, human tragedy like thalidomide before addressing the problem?

This book is like a sequel to Rachel Carson's "Silent Spring," which launched the environmental movement in the 1960s. Not everything Carson forecast has occurred. Not all of her hypotheses have been verified. But her foresight was remarkably clear. "Our Stolen Future" may serve a similar role to "Silent Spring": a warning that disaster is at the end of the thriller and we shouldn't wait for the last page to act. MM

Charles Meyer is editor-in-chief of Minnesota Medicine *and an internist with Consultants–Internal Medicine in Minneapolis.*

CONTOURS Rx

$1,000,000
CLINIC REVENUE INCREASE!
NO INCREASED CALL • NO INCREASED ROUNDS • PROTECTED GEOGRAPHIC AREA

How? • Contours complete multi-track programs of physician monitored weight loss and maintenence.

Includes:
- Detailed medical research, protocols, and guidelines;
- A one-year program detailed by visit;
- A patient/client education package (paid by client);
- And complete support materials.

Successful results for the patient from medications, program learning, and behavior changes. Developed and tested successfully by Lakeside Medical Clinic.

Complete description and details by fax, call 612-537-1000 and ask for Contours details, or fax your request to 537-4852.

4600 Lake Road, Minneapolis, MN 55422–Primary Care Facility



SKI CASCADE LODGE...

LOCATED IN THE HEART of the North Shore Cross Country Ski trail. Cascade Lodge has log cabins, fireplaces, some with whirlpools, rooms in the lodge and a great family restaurant. Cross country ski the miles and miles of groomed trails at Cascade or downhill ski at Lutsen Mt. Ask us about lodging for groups too.
Call or write us for reservations.
HC3 Box 445 Lutsen, MN 55612

CASCADE LODGE
218-387-1112 1-800-322-9543

People and Places Making Medical News

People

Hennepin County Medical Center Administrator

John Bluford has resumed his former position as Hennepin County Medical Center administrator and executive director of Metropolitan Health Plan. He had resigned in August 1996 to pursue an opportunity at a health care facility in Boston. The Hennepin County Board of Commissioners voted unanimously to rescind his resignation.

Bluford returned to Minneapolis when negotiations with the Boston facility ended by mutual agreement. "We determined it was not a good management fit and agreed to terminate our association," said Bluford.

MMA CME Certificates of Award

The Minnesota Medical Association's Continuing Medical Education Accreditation Program presented certificates of award to the following physicians who have served 15 years or longer as CME planners or directors of medical education: **Robert J. Cumming, M.D.**, St. Cloud; **Seymour Handler, M.D.**, Minneapolis; **Ben P. Owens, M.D.**, Hibbing; **John Plunkett, M.D.**, Hastings; **Robert W. Reif, M.D.**, Maplewood; and **Jon K. Wogensen, M.D.**, Burnsville.

Certificates of award were also presented to the following CME sponsors who have been accredited by the MMA for at least 20 years: HealthEast St. John's Hospital, Maplewood; North Memorial Health Care, Minneapolis; St. Cloud Hospital, St. Cloud; and University Medical Center–Mesabi, Hibbing.

Mercy, Unity Physician Awards

Two physicians from Mercy and Unity hospitals, **Allen W. Delzell, M.D.**, and **Frank J. Tycast, M.D.**, have received the hospitals' highest awards. The awards acknowledge clinical skill as well as a history of service to Mercy or Unity, organized medicine, and the community.

Unity Hospital gave Delzell the William J. Carr Physician Recognition Award. Delzell, who has practiced family medicine at the Fridley Plaza Clinic since 1985, joined Unity's medical staff in 1967. He served as member or chair of several of the medical staff's physician committees and was chief of staff in 1976. In the January 1996 issue of *Mpls.St.Paul* magazine, Delzell was listed among 21 top family practitioners in the Twin Cities.

Tycast received the Richard C. Travis Physician Leadership Award from Mercy Hospital. A nephrologist, Tycast founded Kidney Disease and Critical Care Associates and has been on Mercy's medical staff since 1979. He has served as chief of the hospital's medicine section and as a member of the hospital's board of governors. He also has served as spokesperson for the Metropolitan Health Planning Board.

Lakeview Hospital Recognition Awards

Gene Stringer, M.D., and **Robert Meisterling, M.D.**, received recognition awards from Stillwater's Lakeview Hospital medical staff. Stringer has practiced family medicine in Stillwater since 1978. From 1994 to 1995 he was Lakeview chief of staff, and recently he led the development of a new community program in occupational health.

Meisterling has practiced orthopedics in Stillwater since 1979. He has been team physician for Stillwater High School's football team and has been involved in several orthopedic and sports medicine teaching programs. Meisterling served as Lakeview chief of staff from 1992 to 1993 and is a member of the hospital's board of directors.

Abbott Northwestern Community Service Awards

Abbott Northwestern Hospital has given three "Abby" awards for exemplary community service. The award winners were nominated by the public.

Dave Ronning received the award for his efforts to increase safety in the Phillips Neighborhood. He has worked with different agencies to identify more than 70 crack houses. **Sam Riley**, who works at Project for Pride in Living's store at 25th and Chicago Avenue in Minneapolis, was also named for his efforts to make Phillips a safer place to live and work. The third recipient of an Abby was the Phillips/Powderhorn Health Partnership, a community health organization committed to improving maternal and child health access and promoting lead-safe environments and cultural awareness.

Places

'U' Health Faculty Rejects Union

The University of Minnesota's Academic Health Center faculty voted to reject unionization efforts at the university. The vote was 299 for the union and 478 against it. About three-fourths of the eligible voters cast ballots. The AHC includes the Medical School, the School of Dentistry, the School of Nursing, the College of Pharmacy, the School of Public Health, and the College of Veterinary Medicine.

Reaction to the results was mixed. University officials were pleased with the outcome, which seemed to signal a desire to work together in meeting future challenges. Union organizers, however, indicated they would consider contesting the results, citing an atmosphere of fear and uncertainty. "When we went into this, the university administration said they would be neutral on the subject of collective bargaining," said Thomas Walsh, a physics professor and leader of the union movement, in a *St. Paul Pioneer Press* article. "This was by no means the position they took."

Movement toward collective bargaining at the university gained momentum in the fall of 1996 when the Board of Regents proposed a tenure code that would give the board power to lay off tenured faculty members, reduce their pay, and discipline them for having uncooperative attitudes. The Regents passed a compromise tenure code in November that eliminated the layoff provision.

'U' Hospital Workers Sue for Severance Pay

A union representing 700 University Hospital workers has filed suit to preserve severance benefits before the hospital is sold to Fairview Health System. The union's current contract entitles workers to one week of severance pay for each year of employment and allows them to continue their medical insurance for 18 months. When the hospital is sold in January, this contract will become void.

The suit alleges that the sale constitutes a layoff of the workers and, thus, requires the hospital to pay severance benefits to union members before Fairview takes over. If the lawsuit is successful, the university would have to pay several million dollars to the plaintiffs, according to Marshall Tanick of the firm Mansfield and Tanick, which is representing the union.

BCBSM Announces Youth Tobacco Prevention Initiative

Blue Cross Blue Shield of Minnesota has launched "Young Enough to Know Better: Stop Smoking Before It Starts," a statewide education project that encourages discussion between parents and children about tobacco use. The project is in response to studies indicating that smoking among Minnesota children is on the rise.

The centerpiece of the initiative is an award-winning video, "The Adventures of Pep and Fresh." The 10-minute video, available to teachers and parents, was produced by the American Cancer Society (ACS) with support from BCBSM. To receive a loan copy and a curriculum guide, call the ACS at 800/582-5152.

Telemedicine Grant Expands Service to Six Minnesota Hospitals

With a nearly $1 million grant from the Minnesota Department of Public Service, Allina Health System and Rural Health Alliance (RHA) will add six rural hospitals to its telemedicine network of 21 hospitals. The six hospitals joining the network are: District 1 Hospital, Faribault; Minnesota Valley Health Center, LeSeuer; Litchfield Medical Center, Litchfield; Kanebec Hospital, Mora; Northfield Hospital and Skilled Nursing Facility, Northfield; and St. Peter Community Hospital & Health Care Center, St. Peter. The money will be used to purchase and install telemedicine equipment at the six sites.

URGENT CARE PHYSICIANS

HealthEast Immediate Care is offering new opportunities to Physicians interested in an evening and weekend urgent care practice beginning January of 1997! The candidates we seek must have current MD or DO license. Completion of a family practice or emergency medicine residency or completion of other primary care residency with documented clinical competence with full age range of experience is also required for these positions.

A competitive salary is offered to all members. Join our team and be a part of a rapidly developing ambulatory care service line. Please send or fax your CV for immediate consideration to: HealthEast St. Joseph's Hospital, Human Resources, 69 West Exchange Street, St. Paul, MN 55102. FAX: (612) 232-3324.

Immediate Care

HealthEast

Equal Opportunity Employer

BCBSM, Allina Agree to Mediate Contract Dispute

Blue Cross Blue Shield of Minnesota and Allina hospitals have agreed to mediation to resolve contract negotiations regarding pricing for services received by BCBSM members at Allina hospitals. The current contract has been extended to January 31, 1997, to allow time for mediation.

"We want to preserve choice for our members by keeping Allina in our statewide hospital network,"

Southern Arizona's recognized quality leader offers a variety of opportunities from primary care to multi-specialty groups—urban and rural. Within our integrated health organization, we have established both managed care leadership and a premier reputation for quality. Generous compensation and benefit packages and great Southwestern lifestyle for physicians joining our solid, long-term team.

Call Dr. Neil West or Dennis Marshall at (520) 721-5439, or fax CV to (520) 721-5319, attn: Dennis Marshall

said Andy Czajkowski, BCBSM president and chief executive officer, "but we cannot do this at the price of inequitable reimbursement rates for Allina hospital services." Allina has requested reimbursement levels for its hospitals that are 8 percent to 9 percent higher than BCBSM's metro average.

Socioeconomics

HealthPartners Introduces New Health Plan

Bloomington-based HealthPartners has launched a new health plan called Ultimate Choice that offers consumers a package of service options in three price brackets. The plan organizes 7,000 doctors and 350 clinics into 39 groups. Each clinic group provides a certain basic package of services, then decides on what additional service options it will offer. Those options might include business hours, location, types of specialists, or hospital referral patterns. Then the group places itself in one of three price brackets, which differ by about 10 percent. Consumers pay more if their physician and clinic fall in the higher price bracket.

The plan resembles the model initiated by the Buyers Health Care Action Group, a coalition of large employers.

HealthPartners Pursues Partnerships with Rural Hospitals

HealthPartners plans to pursue partnerships with and purchases of small community hospitals throughout Minnesota and western Wisconsin. "It's hard [for hospitals] to be independent in a small community. We have resources to offer them," said Mary Brainerd, the company's vice president for care delivery, in a *St. Paul Pioneer Press* article.

Through these partnerships, HealthPartners intends to share its expertise in managing physician practices, to establish expensive high-tech computerized information systems, and to offer telemedicine links to hospitals that lack the resources to make such improvements themselves. HealthPartners also wants to establish closer ties between the Level 1 trauma center at its St. Paul-Ramsey Medical Center and the emergency departments in rural hospitals.

Community University Health Care Center Drops Prepaid Plan

Unable to comply with state insurance laws, Community University Health Care Center dropped its prepaid health plan for low-income people. The change resulted when the center's director, **Amos Deinard, M.D.**, asked the Minnesota Department of Health if the clinic or prepaid plan should be licensed as an HMO.

Assistant Commissioner of Health **Barbara Colombo** said that because the clinic guaranteed complete medical and hospital coverage through the plan, it qualified as an insurer. State insurance law requires that an insurer have enough resources to protect members against loss of coverage in case the plan experiences financial losses.

Three Area Health Care Companies Trimming Operations

Children's Health Care, Blue Cross Blue Shield of Minnesota, and North Memorial Health Care have all announced plans to trim their operations. "We've seen flat premiums for the insured and a growing number of employers offering self-funded plans. The bottom line is not much new money coming into the system," said Allan Baumgarten, author of "Minnesota Managed Care Review 1996," in a *St. Paul Pioneer Press* article.

Four vice presidents and up to 60 management positions will be affected at Children's Health Care, formed when Minneapolis and St. Paul children's hospitals merged two years ago. BCBSM plans to reduce overhead by closing customer service operations in Fergus Falls, Marshall, and Rochester, which employ a total of 10 people. North Memorial Health Care, which includes North Memorial Medical Center and its clinics, announced it will cut $12 million from its $240 million budget for 1997.

Rates, Trends, Data

Minnesota Is Healthiest State in the Nation

Minnesota tops the list of healthiest states in the nation for the fourth time in seven years, according to the 1996 ReliaStar State Health Rankings. The rankings, widely recognized as the most comprehensive analysis of the relative health of the population in all 50 states, combine 17 components that measure disease, lifestyle, access to health care, occupational safety and disability, and mortality. Minnesota has never come in lower than second place since the rankings were first compiled in 1990.

The next healthiest states after Minnesota are: Utah, Hawaii, New Hampshire, Massachusetts, and Wisconsin. The four states with the least healthy populations are West Virginia (47th), Mississippi and Nevada (tied for 48th), and Louisiana (least healthiest).

CDC Warns of Early Death Risk for Underage Smokers

The Centers for Disease Control and Prevention reported that more than 5 million of today's underage smokers will die of tobacco-related illnesses. "If anything, it's an underestimate of the risks of smoking," said Michael Eriksen, director of the CDC's Office on Smoking and Health, in a Twin Cities-based *Star Tribune* article.

Burt Hirschhorn, M.D., director of the Minnesota Department of Health's Division of Family Health, said that while adult smoking has decreased in Minnesota, smoking among teenagers has increased. Only 20.5 percent of Minnesota adults were smokers in 1995, down from 27.8 percent 10 years ago. But the rate increased among ninth-graders from 12 percent to 18 percent between 1992 and 1995, and from 22 percent to 25 percent among 12th-graders during that same time period.

Tobacco taxes and antismoking campaigns are two ways to reduce smoking rates in general, according to another CDC report. California was one of the first states to impose a higher cigarette tax. In 1995, 15.5 percent of California adults smoked regularly, down from 26 percent in 1984, the CDC said. Since Massachusetts' tobacco education campaign went into effect, smoking rates have dropped by 20 percent. Minnesota's 48-cent tax is tenth highest in the nation.

Innovations

VA Clinic Studies Alzheimer Patients and Driving

Geri Adler, a researcher and social worker from the Minneapolis Veterans Affairs Medical Center's Dementia Clinic, has determined that driving problems may begin at early stages of Alzheimer disease, before symptoms of memory loss or confusion are apparent, because driving requires a combination of skill, judgment, and abstract thinking.

After mixed results in dealing with older drivers suffering from Alzheimer disease and other diseases that cause dementia, the clinic has developed a new strategy. It asks clients and families if, since the onset of the disease, the patient gets lost while driving, has caused or been involved in accidents, drives above or below the speed limit, needs cues from passengers, or has had any traffic violations. If the answer is yes to any of the questions, the patient takes a driving test, either through the state Department of Public Safety or a hospital driving examiner. Patients who choose the latter and fail the test receive counseling with their family from a social worker. If the patient continues to drive, the physician talks with the patient and family; if the patient still insists on driving, the physician writes a letter to state driving examiners.

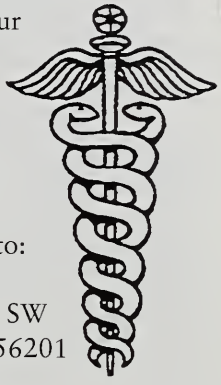
"This can be an extraordinarily volatile topic for families," Adler said in a Twin Cities-based *Star Tribune* article. "Patients hate to hear that they should stop driving almost as much as they hate the Alzheimer diagnosis."

After studying about 50 patients, Adler and her colleagues

PHYSICIAN OPPORTUNITIES

EARN SUPPLEMENTAL INCOME WHILE BECOMING PART OF A NEW MEDICAL WEIGHT LOSS MANAGEMENT PROGRAM.

We are seeking physicians to perform medical screenings in our clinics one or more evenings per week. Flexible schedules available.



Forward C.V. to:
Nutri/System
1025 19th Ave SW
Willmar, MN 56201
320-235-7091
320-235-7092 fax

nutri/system



"It's a great place to live and work."
Andrew David, M.D.

WASHINGTON

The Wenatchee Valley Clinic, a prominent 140+ physician, multi-specialty group practice in the Pacific Northwest has several practice opportunities throughout its practice locations. **Currently, we are seeking:**

WENATCHEE
- **Family Practice w/ OB**
- **Pediatrician**
- **Neurosurgeon**
- **Infectious Disease**
- **Radiation Oncology**
- **Cardiologist**
- **Pathologist**

OMAK/MOSES LAKE
- **Family Practice w/OB**
- **Obstetrician**
- **Ophthalmologist**
- **General Surgeon**
- **Dermatologist**
- **General Internist**
- **Gastroenterologist**

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Send C.V. to the attention of Fred Bockenstedt, M.D., Medical Director -

P.O. Box 489, Wenatchee, WA 98807
FAX (509) 664-7178
CALL (509) 663-8711 ext. 5203

Wenatchee Valley Clinic

discussed their findings at the annual meeting of the Gerontological Society of America.

Medical Research

'U' Conducts First Gene Therapy Trial for Hunter Syndrome

Researchers at the University of Minnesota's Institute of Human Genetics have begun the world's first gene therapy trial for an adult with Hunter syndrome. The rare, inherited disorder is caused by a lack of an enzyme necessary to break down complex carbohydrates in cells.

The therapy, similar to a blood transfusion, involves extracting a patient's white blood cells, genetically correcting them, and injecting the cells back into the patient. A "therapeutic vector" transfers the cells to a normal copy of the gene that codes for the enzyme. The cells then manufacture the enzyme, which corrects the metabolic defect of Hunter syndrome. Because white cells have a short life span, the process is repeated monthly for a year.

Chet Whitley, M.D., associate professor in pediatrics and in the Institute of Human Genetics, said, "We hope to prevent injury to the brain and progressive dementia, which may have implications for other diseases causing progressive dementia such as Alzheimer's." Whitley, lead investigator in the trial, and his colleagues chose to investigate Hunter syndrome because no other systemic treatment exists for the disease.

'U' Researcher Studies Role of Lactation in Reducing Risk of Breast Cancer

David Kiang, M.D., a professor of medical oncology and director of the University of Minnesota's Breast Cancer Research Laboratory, has received a four-year, $509,000 grant to study how the molecular changes that occur during lactation can reduce a woman's risk for breast cancer. Research has shown that lactation before age 20 reduces a woman's lifetime risk of breast cancer 40 percent to 50 percent. Kiang hopes to use the National Cancer Institute grant to develop a way to mimic lactation as a method of reducing breast cancer risk.

Kiang said that breast cancer results from multiple genetic defects that accumulate during a woman's lifetime, often beginning during adolescent breast development. "We know that during lactation there is a significant increase in communication among the mammary epithelial cells where breast cancer develops," he said. "The biological role of this increased communication is to get all epithelial cells working together to produce milk. We believe this increased communication between precancerous cells and their surrounding normal cells at an early age may lead to a reduced risk of cancer."

Kiang and his colleagues are currently unraveling the crucial segment of the gene for the protein that controls the cellular communication channel. By developing a way to mimic lactation, the researchers hope to regulate the protein and to increase intercellular communication, thereby reproducing the beneficial effect of lactation without a woman actually going through the lactation process.

'U' Researcher Finds Effects of Crack, Powdered Cocaine Warrant Similar Penalties

The federal penalty for possession of crack cocaine versus powdered or liquid cocaine is not justified by differences in the effects of the two forms of the drug, according to **Dorothy Hatsukami, Ph.D.**, associate professor of psychiatry at the University of Minnesota.

While the physiological and psychoactive effects of cocaine are similar in any form, a person possessing five grams of crack receives the same punishment as someone with 500 grams of powdered cocaine, a ratio of one to 100, Hatsukami reported in the November 20 *Journal of the American Medical Association.*

"There's no evidence to show that the ratio, and therefore the punishment, is justified," said Hatsukami. "We're not saying there should be a total elimination

of the ratio, but there should be a reduction."

Hatsukami and coinvestigator **Marian Fischman, Ph.D.**, of Columbia University also suggest that because many cocaine users commit crimes as a result of their addiction, they would benefit more from treatment than from imprisonment.

New Blood Thinner Is Better than Aspirin

Clopidogrel, a generic blood thinner, works better than aspirin for preventing heart attacks and strokes in patients with clogged arteries, according to the biggest study ever conducted for a new drug. Researchers at the University of Minnesota and centers in 18 other countries tested more than 19,000 patients with serious artery disease.

Clopidogrel, which produced the same benefits in all 384 centers participating in the study, is safe or safer than aspirin, said **Alan Hirsch, M.D.**, assistant professor of cardiology at the University of Minnesota. The study found that the drug cuts the risk of stroke and heart attack by 33 percent, compared with 25 percent for aspirin. Also, aspirin users were more likely to experience gastrointestinal bleeding as a side effect.

Sanofi and Bristol-Myers Squibb, the drug companies that paid for the study, are jointly developing the drug, which they now are submitting to the Food and Drug Administration for approval.

Mayo Questions Value of Lab Tests

A team of physicians from Rochester's Mayo Clinic found that four common laboratory tests—urinalysis, complete blood count, thyroid studies, and the chemistry panel that measures various blood components—have little value in routine checkups of apparently healthy people. An estimated $30 million worth of these routine tests are done each year.

"The chance of those tests actually finding something is very small," said **Marc Silverstein, M.D.**, who directed the study published in the *American Journal of Medicine*. He and his colleagues calculated the "therapeutic yield," or percent of tests that revealed a need to change treatment, based on 1,508 lab tests for 531 patients. The yield for the chemistry panel was 2.8 percent, and for the other three tests, less than 1 percent. MM

"Stop the Violence" Campaign Order Form

Qnty.	Item
_____	*Stop the violence: physician resource guide:* Contains a diagnostic and treatment guide for domestic violence and domestic violence referral numbers. No charge.
_____	*"It's OK to talk to me about family violence and abuse" buttons:* $25.00 per 25; $37.50 per 50; $50.00 per 100.
_____	*Stop the media violence resource guide for physicians:* Introduces media violence as a part of a public health epidemic and suggests ways for physicians to help. No charge.
_____	*10 Tips for parents to stop the media violence:* Contains 10 ways to assist parents in regulating television viewing in the home. $10.00 per 50; $15.00 per 100.
_____	*Unload It & Lock It:* Contains firearm safety checklist. $15.00 per 50; $20.00 per 100.
_____	*Heart Healthy Tips on Conflict Resolution:* Contains nonviolent alternatives for resolving conflict. $10.00 per 50; $15.00 per 100.
_____	*"Stop the Violence" bumper sticker:* $.50 each.

Your name: _____

Organization: _____

Address: _____

_____

City, State, Zip: _____

Phone: _____

Use this order form to organize your order before phoning us at 612/378-1875 or 800/999-1875, or mail/fax to:

Beth Hoheisel, Communications and Public Relations
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413
Fax 612/378-3875

A bill will be shipped with the ordered items.

MMA
Minnesota Medical Association

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

JANUARY 1997

Jan. 20-24 **Challenges in Hematology and Hematopathology** Mayo Medical Laboratories; Silvertree Hotel, Snowmass, CO. CONTACT: Kathy Bates, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

FEBRUARY 1997

Feb. 6-8 **Twenty-second Annual Winter CME** Minnesota Academy of Physician Assistants and Wisconsin Academy of Physician Assistants; Holiday Inn, Duluth, MN. CONTACT: Cindy Ulshafer, 1825 Center Street, Centerville, MN 55038-9779; 612/653-4736.

Feb. 10-17 **HealthEast 1997 Winter Medical Seminar** HealthEast St. Joseph's Hospital; The Melia Playa Conchal Beach and Golf Resort, Costa Rica. CONTACT: Annette Anderson, 1700 University Avenue West, St. Paul, MN 55104; 612/232-5104.

Feb. 15-19 **Selected Topics in Internal Medicine** Mayo Foundation; Rancho Bernardo Inn and Resort, San Diego, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 21-22 **Advanced Life Support in Obstetrics (ALSO)** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Feb. 28 **Seventh Annual Family Practice Conference** Duluth Clinic; Fitger's Spirit of the North Theatre, Duluth, MN. CONTACT: Rockie Odberg, CME Coordinator, Duluth Clinic, 400 East Third Street, Fifth Avenue, 2ME, Duluth, MN 55805; 218/722-8364.

MARCH 1997

Mar. 1-8 **Ramsey Medical Society Winter CME Conference** Ramsey Medical Society; Sheraton Resort, Xtapa, Mexico. CONTACT: Jennifer Stendahl, Ramsey Medical Society, PO Box 131690, St. Paul, MN 55113; 612/362-3701.

Mar. 6-7 **Current Issues in Phlebotomy and Point-of-Care Testing** Mayo Medical Laboratories; Renaissance Harborplace Hotel, Baltimore, MD. CONTACT: Kathy Bates or Julie McAdams, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Mar. 7 **Osteoporosis Conference** Hennepin County Medical Center; Doubletree Grand Hotel, Bloomington, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Mar. 7-8 **Advanced Trauma Life Support Course** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Mar. 13-14 **Research Statistics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Mar. 14-15 **Current Issues in Cancer Prevention, Detection, and Treatment** Mayo Foundation; Mayo Clinic, Rochester,

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

INFECTION CONTROL

Mar. 21 **HIV Primary Care Conference** Allina Health System, Children's Health Care, Duluth Clinic, Health East, Health Partners–St. Paul-Ramsey Medical Center, Hennepin County Medical Center, Institute for Research and Education–Health System Minnesota, Midwest Aids Training and Education Center, Minneapolis Education Center–Department of Veterans Affairs, and the University of Minnesota; The Metropolitan Conference Center, Minneapolis, MN. CONTACT: Allina Office of Clinical Education and Research, 612/992-2424.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

Videotapes: **Emerging Infectious Diseases** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

APRIL 1997

Apr. 4-5 **Innovative Concepts for Stroke Care: Preparing for the 21st Century** St. Luke's Hospital and Regional Trauma Center; Holiday Inn, Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Apr. 17-18 **Research Statistics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Apr. 17-19 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

MAY 1997

May 2-3 **Cultural Diversity Conference** Hennepin County Medical Center; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

May 6-9 **Fourth International Surgical Pathology Symposium** Mayo Medical Laboratories; Hotel Estoril Sol, Cascais, Portugal. CONTACT: Kathy Bates, Mayo Medical Laboratories, Office of Continuing Education, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

May 16 **John I. Coe Symposium** Hennepin County Medical Center; St. Cloud Civic Center, St. Cloud, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

SEPTEMBER 1997

Sept. 12-13 **Advanced Trauma Life Support Course** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Sept. 12-14 **Annual Ambulance Medical Directors Retreat** Hennepin County Medical Center; Radisson Arrowwood, Alexandria, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 800/263-4262.

Sept. 19 **Contemporary Issues in Hemodialysis** Hennepin County Medical Center; Sheraton Midway Hotel, St. Paul, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 19 **Second Annual Regional Ob/Gyn Conference** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Sept. 26-27 **Statistical Computing** Hennepin County Medical Center; Brainerd, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

OCTOBER 1997

Oct. 2-3 **Annual Forensic Science Seminar** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 9-10 **Clinical Research** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

MMA-Accredited CME Sponsors

The Minnesota Medical Association is the accrediting agency for Minnesota institutions that regularly sponsor continuing medical education activities for local physicians. Accreditation gives CME sponsors responsibility for conducting high-quality CME programs and for designating credit for CME activities. CME programs must comply with the MMA's "Essentials for the Accreditation of Sponsors of Continuing Medical Education" and the ACCME's "Standards for Commercial Support of CME" and "Standards for Enduring Materials."

The MMA Committee on Accreditation and CME has recently reaccredited the following CME sponsors:

- HealthEast St. John's Hospital, Maplewood
- Olmsted Medical Center, Rochester

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800 DIAL-MMA.

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., January 15 for March ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary $80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Olmsted Medical Center is seeking BC/BE physicians in the following specialties: emergency medicine and family medicine. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. Positions currently open include emergency room and family medicine departments in Rochester and branch office locations. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes nine branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (5/96-R)

Fergus Falls Medical Group is expanding its 33-physician multispecialty clinic and is seeking physicians in the following specialties: dermatology, family practice, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (1/97-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice-trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Rent Our Caribbean-Shore Home—Silver Sands, Jamaica. Cook, maid, your own pool. Sleeps eight. Great for families, groups. Rent from $1,995/week winter, $1,395 off-season. 800/260-1120. (10/96-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Physician Needed to work part time in multidisciplinary clinic. All calls confidential to doctor's private line, 612/889-5973. (6/96-R)

Ski Big Sky Montana: Three-bedroom, three-bathroom, non-smoking condominium. Ski-in, ski-out. Washer/dryer, pool, hot tubs, heated garage, daily maid service; 612/483-1163. 2-1/97

University of Minnesota–Dentisty Faculty: University of Minnesota School of Dentistry invites applicants through 6/30/97 for part-time, non-regular faculty for consultative diagnostic and treatment planning services in specialty clinics. Medical degree is required with training and experience in otolaryngology or reconstructive surgery cleft palate patient care. Faculty rank dependent upon experience and training. Send résumé (indicating specialty or area[s] of clinical expertise) to Dean's Office, University of Minnesota School of Dentistry, 15-209 Moos Tower, 515 Delaware Street SE, Minneapolis, MN 55455. The University of Minnesota is an equal opportunity educator and employer. 2-1/97

Family Practice: Primary care with a personal touch—that's Regina Medical Group. Our well-established group has an opportunity for a BC/BE with a committed, community-based practice approach to join our Hastings, Minnesota, or Prescott, Wisconsin, site. Excellent call, salary, and benefits. Forward your CV to Mark Kapler, Vice President, Regina Medical Group, 1175 Nininger Road, Hastings, MN 55033; 612/480-4219. 1-1/97

Office Space Available—Southdale Medical Building: Part-time sublease. Ideal for satellite office. Fully equipped and staffed. Terms negotiable. For more information call 612/927-4071. 1-1/97

Join Our Close-Knit Physicians and Staff dedicated to the professional care and comfort of our patients. Very busy orthopedic practice needs a fourth physician in our growing family. No capitated plans. Limited managed care. Beautiful, brand-new building in idyllic woodland setting. Northwoods area offers year-round, abundant recreational activities, including golf, skiing, hunting, fishing, and many more. Good schools, excellent local airport. Contact Susan Timmons, Northland Orthopedic Associates, 444 East Timber Drive, Box 498, Rhinelander, WI 54501; 715/369-2300. 1-1/97

Near Twin Cities: Community psychiatry with emphasis on child and adolescent populations. Practice offers highly qualified colleagues, a multidisciplined approach, beautiful facilities, competitive salary and benefits programs. Community offers impressive growth, good school choices, convenient access to the Twin Cities, many nearby lakes, and safe neighborhoods. Contact Verne Meyer at 800/967-2711, or E-mail delacore@hutchtel.net, or fax 320/587-7252. 2-2/97

Geriatric Health Symposium on February 17, 1997: Franciscan Skemp Healthcare, La Crosse, Wisconsin. Contact Dr. Thomas Loepfe, Franciscan Skemp Healthcare, 700 West Avenue South, La Crosse, WI 54601; 608/785-0940, ext. 6717. 2-2/97

Staff Care, Inc.

"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS



- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging

Ask for:

John Moberly, ext. 2381 or

Melanie McReynolds, ext. 2387

(800) 685-2272

http://www.locumsnet.com

Staff Care is proud to sponsor the Country Doctor of the Year Award

Unable to place J-1 or H-1 physicians

General Internist

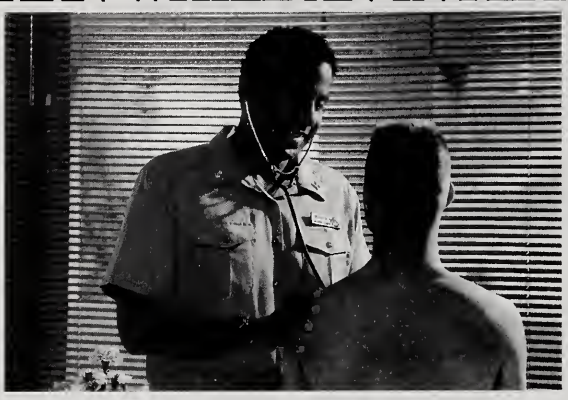
CentraCare Clinic, a growing 65 physician multispecialty group based in St. Cloud, MN, seeks a general internist to join an established internist at our satellite clinic in Little Falls, MN. Enjoy the support of a large multispecialty group, while enjoying the benefits of smaller town living.

Little Falls is a picturesque community of 15,000 located 30 miles north of St. Cloud and 100 miles northwest of the Twin Cities. Little Falls is the gateway to the beautiful Brainerd lakes area. With outstanding schools, affordable housing and peaceful neighborhoods, Little Falls is an excellent place to raise a family.

Please contact:
John Schnettler
St. Cloud Hospital
1406 Sixth Ave. N.
St. Cloud, MN 56303
1-800-835-6652

CENTRACare CLINIC

EARN WHILE AN INTERN



WE GIVE YOU MORE PLACES TO GO WITH YOUR CAREER

The Navy is accepting applications for: Orthopedic, Family Practice, OB/GYN, Undersea Medicine, General Surgery, Anesthesiology, Flight Surgeon and others.

Location and Benefits:

- Excellent Salary And Benefits Packages
- Challenging Assignments
- Relocation Expenses Paid
- Professional Development
- Worldwide Location

FOR MORE INFORMATION CALL: 1-800-247-0507 (MN)
1-800-558-0068 (WI)

NAVY PHYSICIAN You and the Navy. Full Speed Ahead.

Emergency Medicine: Full-time and moonlighting positions available at Lakeview Hospital in Stillwater, Minnesota. Eight thousand patients per year, low acuity, excellent back-up and remuneration. Great opportunity for emergency medicine or family practice residents to pick up added income and experience. Also, multispecialty group looking to add third ED/urgent care MD. Contact Tom Monahan, M.D., Stillwater Medical Group, P.A., 612/439-1234. 2-2/97

District Medical Director: Excellent opportunity in a large multispecialty group for a BC physician in family practice or internal medicine. This leadership opportunity is based in a northern Twin Cities suburb and requires 50 percent administrative time and 50 percent clinical care. The practice is part of a large integrated health care system and offers a competitive salary and benefits along with a generous call schedule. For confidential inquiry, please contact Jolayne Fisher, Allina Health System, 612/992-2361 or 800/248-4921, or fax 612/992-3828. 3-3/97

Vacation Home Rental: Big Island of Hawaii. Elegant, secluded, three-bedroom home in North Kohala Mountains overlooking ocean. Spectacular hiking, golf, bicycling, horseback riding nearby. Rental weekly, monthly. Call 612/433-5443. 2-2/97



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 29-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- PEDIATRICS
- NEUROLOGY
- ONCOLOGY
- INTERNAL MEDICINE/PULMONOLOGY
- FAMILY PRACTICE
- EMERGENCY MEDICINE

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

A Healthier Future

Southern Minnesota

*Seeking quality primary care trained or emergency medicine physician(s) to practice in **Fairmont, Owatonna and Worthington**.*

- Stellar Emergency Medicine Practice
- Full-time, regular part-time and moonlighting opportunities
- No restrictive covenants
- Fully accredited CME programs
- St. Paul malpractice insurance
- Competitive bonus, benefit and compensation packages.

ACUTE CARE, INC.

Respond to Melissa Milliken, CMSC, Director of Development, 515-964-2772, 800-729-7813 or send CV to P.O. Box 515, Ankeny, Iowa 50021.

Excellent Practice Opportunities

URGENT CARE DIRECTOR: Seeking a full-time Urgent Care Director to work both in an administrative function and direct patient care.

FAMILY PRACTICE: Join 27-physician Family Practice Dept. with call one weekday per month and one weekend per month.

OCCUPATIONAL MEDICINE: Join busy Occupational Medicine Dept. with emphasis in injured worker care, medical surveillance and industrial account consulting.

Columbia Park Medical Group is an independent, physician-owned, multi-specialty group practice. Our 65-physician practice has three clinic locations in the northern Minneapolis suburbs. We offer an excellent salary and benefits package with partnership opportunity.

Call for more information or send CV to:

Columbia Park Medical Group
6401 University Avenue N.E., #200
Minneapolis, MN 55432
Stephanie Clark (612) 586-5876

South Dakota
Room to Grow

Just imagine...the luxury of outdoor life in a traditional practice in Mitchell, South Dakota. The clinic is seeking a fifth BC/BE FP with OB. Quality family life, low crime rate...and **No State Income Tax!** Above national average compensation and comprehensive benefit package. Call today! Or send your CV to Pam Martin, Business Manager, Mitchell Clinic, 818 W. Havens, Mitchell, SD, 57301. 1-605-996-7772



mayo

Mayo Clinic–Rochester, Department of Otorhinolaryngology, is seeking a board-certified otolaryngologist to do non-surgical practice and offers an excellent salary/benefits package, including malpractice coverage. Relocation assistance provided. For confidential information, please send a current CV to Thomas J. McDonald, M.D., Chair, Department of Otorhinolaryngology, Mayo Clinic, 200 First Street SW, Rochester, Minnesota 55905.

Mayo Foundation is an affirmative action and equal opportunity educator and employer.

MEDICAL DIRECTOR

RTW, Inc., a dynamic organization and leader of the transformation of the workers' compensation system in the United States, is seeking a part-time medical director. Our organization has developed a powerful economic model to transform the workers' compensation system for employers. We are looking for a medical physician with strong occupational health and/or workers' compensation background to facilitate medical case management by acting as a liaison between our nurse case managers and physician providers. Strong interpersonal communication and negotiation skills required.

Please mail/fax your resume (C.V.) to:

RTW, Inc.
ATTN: Human Resources
8500 Normandale Lake Blvd.
Suite 1400
Bloomington, MN 55437

Mankato, Minnesota: Full-time psychiatrist. Excellent opportunity for BC/BE psychiatrist to join our multidisciplinary team. Competitive salary and benefits package. Mankato is a high-quality town, 70 miles south of Minneapolis. Excellent schools and recreational activities. For more information, contact Ed Sathoff, M.D., or Patricia Blumenreich, M.D., at 507/387-3195, or send/fax CV to Psychiatric Clinic, 410 Jackson Street, Suite 200, Mankato, MN 56001; Fax: 507/625-2224. 1-1/97

JANUARY 1997 INDEX TO ADVERTISERS

Acute Care Inc. 62
Air Force Health Professionals–Ft. Snelling 19
Alexandria Clinic, P.A. 62
Aspen Medical Group 26
Cascade Lodge 51
Centra Care Clinic 61
Central Minnesota Group Health Plan 30
Columbia Park Medical Group 63
Fairview Clinic Services 46
HealthEast St. Joseph's Hospital 53
HealthEast Bethesda ..... Cover 2
HealthPartners 54
Hennepin County Medical Center 5
Lakeside Clinic 51
Leonard, Street & Deinard 27
Mayo Foundation 63
MEDPAC 41
MMA 7, 57
MMBR ..... Cover 3, 21, 28, 31, 32
Mitchell Clinic 63
Multicare Associates of the Twin Cities 27
Navy Recruiting District 62
North Memorial Medical Programs 11
Nutri/System 55
RTW, Inc. 64
St. Cloud Medical Group 26
St. Paul-Ramsey CME 11
Staff Care, Inc. 61
THC Minneapolis. 10
U.S. West Communication. 3
University of Minnesota ..... Cover 4
Wenatchee Valley Clinic 56
Whitesell Medical Locums, Ltd. 27

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

STACKS
HEALTH SCIENCES L
UNIVERSITY OF MARYLAND AT
BALTIMORE
FEB 26 1997
NOT IN CIRC.
REC'D.



FEBRUARY 1997

HEALING THE WOUNDS OF WAR



THE
MEDICAL PROTECTIVE COMPANY

Professional Protection Exclusively since 1899

To reach your local office, call 800-344-1899.

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Normandy, July 1944: Litter bearers carry wounded from the front line to the battalion aid station.

DEPARTMENTS

2 ..... Editor's Notebook

6 ..... HealthScene Minnesota

46 .... Author Instructions

53 .... News Clips

62 .... CME in Minnesota

64 .... Classified Ads

68 .... Index to Advertisers

FACE TO FACE

8 **Embracing Change** ..... Kim Palmer
Under the leadership of Robert Petzel, M.D., the VA's Upper Midwest Network prepares to meet the challenges of the 21st century.

PERSPECTIVES

12 **The Reserve Physician** ..... Michael J. Murray, M.D., Ph.D.
Where quality medical care is desperately needed, the Armed Forces often values a good soldier more than a good physician.

FEATURE STORY

16 **Healing the Wounds of War** ..... Douglas Clement
Three physicians share vivid memories of very different wartime experiences.

SPECIAL REPORTS

24 **The Changing Face of the Veterans Affairs Health Care System** ..... Kenneth W. Kizer, M.D., M.P.H.
After five decades, the U.S. Department of Veterans Affairs health care system is restructuring the way it operates to address managed care issues and to better serve its patients.

29 **Posttraumatic Stress Disorder Among Veterans** ..... Michael E. Dieperink, M.D., Ph.D.
PTSD is a complex syndrome, but research involving veterans is broadening our understanding.

CLINICAL & HEALTH AFFAIRS

43 **Caring for Persons with AIDS in Greater Minnesota** ..... Heather Chial, B.A., and Barbara A. Elliott, Ph.D.

PUBLIC HEALTH REPORT

48 **Screening Pregnant Women for HIV** ..... Virginia R. Lupo, M.D.
Because available drug therapy can potentially prevent maternal-infant HIV transmission, health care providers should counsel all pregnant women regarding HIV testing.

MEDICINE LAW & POLICY

51 **Informed Consent: Still a Physician's Duty** ..... Shirley Qual, J.D.
Minnesota law leaves many questions regarding informed consent unanswered, but this attorney has some advice.

33 *The* Monitor

Highlights ..... *Talking points on 2 percent provider tax • Screen for alcohol abuse • Viewpoint: Do we have enough quality yet?*

War Is Our Worst Chronic Disease

"War is a contagion," wrote Franklin D. Roosevelt. And it's true. War is our worst chronic disease. It kills millions, maims more. It molds generations. Its morbidity lasts centuries. It never goes away. That kind of disease is a tall order for medicine. Although civilians don't escape the fallout of war, medicine in the military handles the frontline. This issue of *Minnesota Medicine* is about military medicine. What do wars past and present mean for society and the practice of medicine?



"Duty and necessity force military physicians to look past the carnage and just treat."

The disease starts in the trenches, and our feature story (page 16) tells the sagas of three physicians in three vastly different conflicts. For Dr. Bill McConahey, World War II featured total mobilization of the United States against an evil foe. It united a depression-weary nation. In Vietnam, Dr. George Nemanich saw an undeclared war against an undefinable enemy imposed on an undecided nation. It divided and confused an already uneasy country. Dr. Jeffrey Welna witnessed the Gulf War pitting a dark force against a United States haunted by echoes of Vietnam. It showed the nation what future conflicts will look like. Different conflicts, different personal stories, different retrospective, but the same senseless, premature death.

Keeping the peace in the military can be daunting, as depicted in our perspectives article by Dr. Michael Murray (page 12), an anesthesiologist with one foot in the Army Reserves and one in private practice.

Combat is just the beginning for medicine. Survivors come home and must be cared for. The VA medical system was World War II's answer for the needs of returning combatants. Since 1946, the Veterans Administration has become a billion-dollar experiment in socialized medicine, with the federal government providing health care to graduates of the military experience. U.S. Department of Veterans Affairs Under Secretary for Health Dr. Kenneth Kizer's special report (page 24) and the profile of Dr. Robert Petzel (page 8) show a thriving VA repositioning itself for the next 50 years.

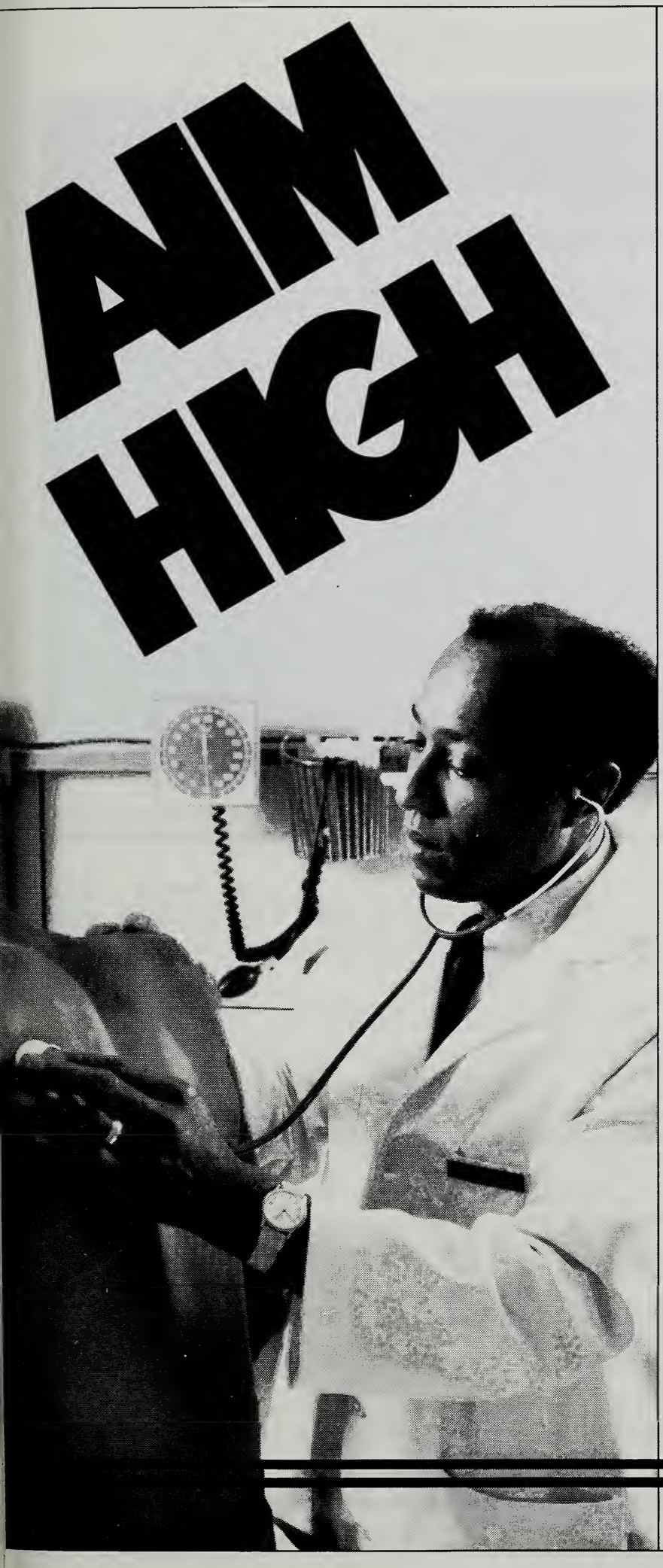
For some, the terror of combat never fades. The bombs and the blood live in the flashbacks of the victims of posttraumatic stress disorder. As described in a second special report (page 29), remembered war experiences are a disease as disabling as AIDS or cancer.

In addition to our focus on military medicine, this month's issue includes three articles related to HIV/AIDS. A clinical article (page 43) identifies the needs of caregivers for persons with AIDS in greater Minnesota. A public health report (page 48) discusses the latest research surrounding the benefits of screening pregnant women for HIV. We've also included an article on informed consent (page 51), which discusses the topic as it applies to HIV testing and outlines physicians' responsibilities before performing any treatment or procedure involving special risk.

Medicine has had a peculiar relationship with war. During war, medics clean up the human mess left by bullets and bombs. After war, medicine patches the bodies and souls ravaged by combat. Medicine participates in the disease that is war but, like the immune system, keeps trying to restore the system to equilibrium. Duty and necessity force military physicians to look past the carnage and just treat.

War will not likely go away any time soon. Armies will still need hospitals and doctors to staff them. Vets will still need VAs to treat them. Medicine will still need to study and treat this disease called war. Future McConaheys, Nemanichs, and Welnas will see more blood, bind more wounds, and try to do no harm.

–Charles R. Meyer, M.D., Editor-in-Chief



SPECIALIZE IN AIR FORCE MEDICINE.

ER Physicians. Radiologists. OB/GYNs and other specialists! Today's Air Force gives you the freedom to specialize without the financial overhead of running a private practice. Talk to an Air Force medical program manager about the tremendous benefits of becoming an Air Force medical officer:

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay each year

Examine your future in the Air Force. Learn if you qualify. Call

USAF Health Professions
Toll Free
1-800-423-USAF

AIR FORCE

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor and Graphic Designer
Susan Rodsjo

Consulting Editors
Lenore Franzen
Meredith McNab

Publications Assistant
Juliet Ramotar

Public Health Reports Editor
Barbara Yawn, M.D., M.Sc.

Graphic Designer
Michael May

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine.* The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/999-1875.

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine.* Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1996-97 Officers

President
Raymond G. Christensen, M.D.

President-Elect
Kent S. Wilson, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Paul R. Hamann, M.D.

Secretary
Judith F. Shank, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Anthony C. Jaspers, M.D.

Vice Speaker of the House
Blanton Bessinger, M.D.

Past President
Michael J. Murray, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Trinky Pollard

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth Crabb, M.D.
Theodore L. Fritsche, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875.

E-mail: mma@mnmed.org

Web site: www.mnmed.org

At many hospitals, physicians battle every day with things invisible to the naked eye.

At North Memorial, we think you should spend less time worrying about your career and more time worrying about your patients. That's why we believe in policies that are also beneficial to Internal Medicine and Family Practice Physicians. If you'd like to practice in a truly innovative medical community in Minneapolis or a surrounding suburb, call a Physician Placement Coordinator at 1-800-275-4790.

Such as hospital policies.



© 1995 North Memorial

North Memorial

HealthPartners
St. Paul-Ramsey Medical Center

CME

640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

Continuing Medical Education
1997 Winter/Spring Conference Schedule

Burn Care Today	Feb. 20-21
Family Medicine Today	March 20-21
Annual Occupational Medicine Update	March 21
Agricultural Medicine	April 2
Annual Obstetrics & Gynecology Update	April 3-4
Annual ENT Update	April 4
Critical Care 1997	April 17-18
NIOSH-Approved Spirometry	April 30-May 1

Information and Registration:
Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612-221-3992 • Fax 612-292-4773

St. Paul-Ramsey Medical Center/Ramsey Clinic/Ramsey Foundation are Members of the HealthPartners Family of Health Care Organizations

HealthPartners
RAMSEY



Follow the Money

When the dispute between Blue Cross and Blue Shield of Minnesota (BCBSM) and Allina Health System made headlines in December, Minnesotans shook their heads in amazement. "Things are getting ugly," they lamented, at least by Minnesota nice standards.

Why should anyone be surprised that the state's largest health plan company and largest provider system are vigorously duking it out over the price of hospital services? Money and patients—the two resources at stake—are in short supply. Providers and facilities, on the other hand, are plentiful.

BCBSM and Allina are not the only two facing these financial pressures; all the major health plans and provider systems are under the proverbial gun and have announced initiatives to try to gain control of their finances. Some examples:

- Fairview announced layoffs it attributes to HealthPartners' decision to shift a large number of inpatient admissions to North Memorial and Methodist Hospitals;
- North Memorial, not optimistic that the new business will boost its bottom line, announced plans to cut millions from its 1997 budget;
- HealthEast will reduce staff and close its two St. Paul hospitals, replacing them with a much smaller inpatient facility in fast-growing suburban Woodbury; and
- Having held premium prices low to maintain market share, Medica (Allina wearing its health plan hat) now wants to trim $37 million in expenses, starting with provider payments and pharmaceutical costs.



"HealthScene Minnesota" is a new occasional column by Allan Baumgarten, J.D., a consultant on health care policy, finance, and local market strategies and the author of "Minnesota Managed Care Review" and "Colorado Managed Care Review," annual reports analyzing key trends in those health care markets.

In the good old days, actuaries calculated how much premium revenue was needed to pay anticipated claims, and insurers set their prices accordingly. In the past few years, however, purchasers have exerted pressure to hold down price increases, in some cases winning premium reductions. This recent trend means no new money is coming into the system. Operating inefficiencies that once were glossed over are now on the chopping block. Today, consulting actuaries tell clients how to keep utilization within available premium dollars.

The low premium increases of the mid-1990s have had a lasting impact on the business of health care. Everyone is trying to buy services at the lowest possible margin. Self-funded employers won't pay insurers a premium to manage their risk, but they want the health plans to give them the most favorable fee schedules. In turn, health plans don't want to capitate providers and give them the opportunity to profit by better controlling utilization.

Minnesota may pride itself on having a nonprofit, mission-driven health care system. But all the players need money, including surplus, to stay in business. Battles over fees and the continuing push to hold down costs are only the beginning. In the future, we will see providers struggling to align capacity with demand and health plans trying to demonstrate that the value they bring purchasers and providers justifies the money they keep. MM

When it comes to earning miles, these cards can really fly.



Apply now and earn 3,000 WorldPerks Bonus Miles when you become a cardmember.*
Available only by phone and only to MMA and MMGMA members and spouses.

WorldPerks® Visa.® The only Visa card that rewards you with WorldPerks miles. Earn 1 mile for every dollar in retail purchases with your WorldPerks Visa card. Earn WorldPerks miles for every dinner you buy. Every tank of gas. Every gift. Every day, every week, every month. Make a purchase at more than 11 million locations with your WorldPerks Visa, and you'll fly free faster on Northwest Airlines. We have made applying easy. Simply call 612-623-2860 or toll free 1-800-298-MMBR (6627).

MMBR
MINNESOTA MEDICAL
BUSINESS RESOURCES
A physician-owned, for profit corporation of the MMA and HMS

To apply, call:
612-623-2860 or
toll free 1-800-298-MMBR (6627)

1995. *Excludes current WorldPerks Visa cardmembers. Applicants must apply by phone by June 30, 1996. The 3,000 WorldPerks bonus miles will be awarded upon credit approval and after the first transaction posts to your WorldPerks Visa account. Please allow 3-4 weeks for miles to be posted to your account. Use of the credit card account will be subject to the terms and conditions of the Cardholder Agreement provided to you when your card is issued. Complete terms and conditions of participation in the WorldPerks program are contained in the WorldPerks Member's Guide. Creditor is First Bank of South Dakota (National Association), Sioux Falls.

Embracing Change

Under the leadership of Robert Petzel, the Department of Veterans Affairs Upper Midwest Network prepares to meet the challenges of the 21st century.

BY KIM PALMER

Change can be unsettling, muses Robert "Randy" Petzel, M.D., from his office overlooking the Veterans Affairs (VA) Medical Center in Minneapolis. But it can also be invigorating. After 16 years as the Minneapolis VA's chief of staff, the nephrologist was tapped for a new position in 1996. He now heads the VA Upper Midwest Network, an integrated service network consisting of VA medical facilities in Minnesota and the Dakotas, created when the federal Department of Veterans Affairs reorganized its 172 facilities last year.

"It was like a tonic for me," he says. "It was renewing." Petzel was clearly ready for new challenges. Being at the helm of a regional network rather than a self-contained facility gives him an opportunity to solve problems on a bigger, systemwide scale. "We had dreamed of creating this network," he says.

Now, as the VA undertakes a wide slate of reforms designed to help it survive and thrive into the next century, one of Petzel's biggest challenges is inspiring the VA's staff to accept and embrace change. His optimism should aid the effort. "Change is not a threat," he says. "It's an opportunity to do something different.

"The business world is changing, health care is changing, and the VA is changing," he continues. "Organizations used to face change followed by a period of stability. Now we live in a culture of change—continuous, evolutionary change."



PHOTOGRAPH BY BRUCE BAIRD

What has spurred reform within the VA system? Certainly managed care forces are altering the landscape for all health care providers. In addition, as the second largest department in the federal government, the VA is under constant scrutiny. "Congress and the people are looking at every program and asking, 'Does it provide value?'" says Petzel. And the aging of Americans—marked by the swell of baby-boomers advancing into middle and old age—has a special resonance for the VA, whose primary service population is about a decade older than the nation's at large. "We're leading the graying of America," Petzel notes. This has cost implications for the VA because older patients tend to require more care and a greater variety of services than younger patients, he adds.

"Nothing will happen today or tomorrow," Petzel says. "But if we don't meet the challenges we face, our patients will leave us and find other providers."

A Future Vision

Petzel is optimistic the VA will survive because of its wealth of assets: a well-trained work force, a solid reputation, customer loyalty, and current national leadership. Under the direction of Kenneth Kizer, M.D., under secretary for health, the Department of Veterans Affairs "recognizes what the VA needs to do to survive in the 21st century," says Petzel. "That hasn't always been the case. The national department has a vision and can articulate what the VA needs to do to get there" (see related article, page 24).

The VA is committed to being competitive in five "domains of value," Petzel says. The first three are quality medical care, cost-effectiveness, and geographic accessibility for patients. Fourth, the VA must deliver a satisfying patient experience; this would include short waits for appointments, courteous and kind health care providers, high-quality patient materials, and adequate parking—"a customer-oriented focus," as Petzel explains. Finally, the VA must strive to always improve patients' health, constantly asking "did we make the patient better?"

The largest facility of the six in the Upper Midwest Network, the Minneapolis VA is more competitive than many VA facilities nationwide, Petzel notes, "because of the state's more mature managed care market."

The VA as an institution is closer to some of the five goals than others. "We know we provide a technically high-quality product," Petzel says. "The care the VA

provides is as good as anyplace else. We know we're cost-effective. But we're not geographically accessible to many of our patients, and we haven't always provided a satisfying patient experience."

The Upper Midwest Network

The VA Upper Midwest Network includes medical facilities in Minneapolis and St. Cloud, Minnesota; Fargo, North Dakota; and in Sioux Falls, Fort Mead, and Hot Springs, South Dakota. (The latter two facilities have been combined administratively to form the Black Hills Health Care System.) Together these facilities serve 770,000 eligible veterans.

The VA formed networks so that it could provide a more integrated continuum of care for its population, Petzel says. "Each facility used to operate somewhat in isolation. Integrating our systems allows us to begin talking about how we can best deliver care to a wider population. It forces us to begin thinking in broader terms about veterans' health. And there are cost savings to integrating our administrative systems." The consolidation of the two Black Hills facilities a year ago has already saved approximately $1.5 million in administrative costs, Petzel notes.

The VA facilities in the Upper Midwest Network have taken several steps toward integrated delivery of services, Petzel says. "We now have clinical practice guidelines in all facilities. We have set up a system for referrals and case management, and we have implemented an integrated patient care database." The Upper Midwest Network also has a common cost accounting system and has integrated budgeting and other administrative processes.

To improve accessibility, the Upper Midwest Network has a five-year plan to provide care to veterans through primary care clinics. The VA will contract with medical providers throughout Minnesota and the Dakotas. "We've done focus groups with providers," says Petzel. "They are interested and, in some cases, enthusiastic."

To provide patients a more "satisfying experience," the network is reducing the waiting time for an appointment. "In one year, we've dropped from a three-to-four-week wait to see a primary care physician to a three-day wait," Petzel says. "We've done it by eliminating unnecessary appointments and spending some additional resources." An increased emphasis on outpatient care rather than hospital care has resulted in reducing the number of hospital beds within the network from 1,513 in 1992 to 1,096 in 1996. "That space and those people are now devoted to ambulatory care," Petzel adds.

Changes for Physicians

VA physicians, along with many physicians nationwide, are adapting to change and learning new skills to keep pace with the market's needs. Some specialists are being retrained to deliver primary care. As the VA continues to computerize more and more of its patient data, physicians are encouraged to hone their communication skills and acquire computer proficiency. The VA's current goal is for each employee to have 40 hours of training annually. "Having that as a goal for the organization is a big change," Petzel says.

What probably has had the biggest impact on VA physicians in Minnesota and the Dakotas is the implementation of clinical practice guidelines, Petzel says. "Our physicians now have a uniform standard of practice to turn to, which is a real positive. But it also reduces physician independence and autonomy somewhat."

The Making of a Leader

Petzel himself long dreamed of being a doctor. "As a child, I lived next door to a family doctor, and I decided I wanted to be one. I liked the idea of service; being a doctor seemed valuable, worthwhile." But by the time he enrolled at St. Olaf College in Northfield, Minnesota, in 1961, Petzel had doubts and decided to major in political science and pursue a career in international relations instead. Then a biology professor suggested graduate school in biology. "I thought, if he thinks I can make it in graduate school, maybe I can make it in medical school," says Petzel. "If it hadn't been for him, I'm not sure I would have done it. I'm very grateful."

He enrolled in medical school at Northwestern University in Chicago. Following a residency at the University of Minnesota and a two-year nephrology fellowship at the Minneapolis VA, Petzel joined the VA staff in 1975, where he quickly moved into administration, becoming chief of staff in 1980. Administration appealed to him because it offered the opportunity to make systemwide improvements. "I could see that a lot of issues and problems cut across department lines. I thought that if I could work across those lines, it would be easier to solve the problems," says Petzel.

As an executive, Petzel believes his greatest strength is his ability to collaborate while keeping an eye on the big picture. "My style is to include all the people involved in an issue and build consensus," he says. "And I do have a vision of where this network needs to go and what we need to become." MM

Kim Palmer is a Minneapolis free-lance writer.

CONTINUING MEDICAL EDUCATION

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

FEBRUARY, 1997

15 PARKINSON'S DISEASE UPDATE
Presented by: Minneapolis Neuroscience Institute
Location: Abbott Northwestern Hospital, Minneapolis

MARCH, 1997

1 COMMON RETINAL PROBLEMS
Presented by: VitroRetinal Surgery, P.A.
Location: Wyndham Garden Hotel, Bloomington

7 CREDENTIALING CONFERENCE
Presented by: Allina Health System
Location: Hotel Sofitel, Bloomington

21 HIV PRIMARY CARE UPDATE
Location: The Metropolitan, Golden Valley

APRIL, 1997

4 CARDIOLOGY UPDATE
Presented by: Minneapolis Heart Institute Foundation
Location: Doubletree Grand Hotel, Bloomington

15-16 ADVANCED TRAUMA LIFE SUPPORT (ATLS)
Presented by: Allina Health System
Location: United Hospital, St. Paul

17 PRINCIPLES OF DIABETES
Presented by: Allina Health System
Location: Mercy Hospital, Coon Rapids

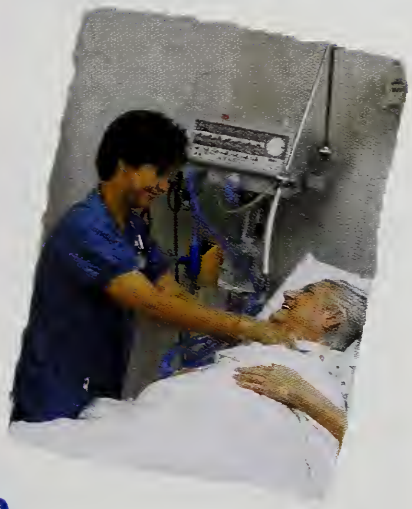
MAY, 1997

14 HEALTH CARE FOR THE UNDERSERVED
Presented by: United Family Health Center
Location: United Hospital, St. Paul

For more information, contact the Allina Office of Clinical Education - (612) 992-2424

™ A Trademark of Allina Health System

SPECIAL CARE
FOR SPECIAL PATIENTS



Recovery from an illness, accident or injury requires experienced medical professionals, state of the art equipment and technologically advanced therapies. It also requires a comforting, nurturing staff, a "home away from home" environment and family involvement in patient care. Our hospital is dedicated to the recovery of critically ill patients. And we're with you every step of the way, with cost effective care that includes:

- *Pulmonary/Ventilator Program*
- *Wound Care Program*
- *Medically Complex Program*
- *Low Tolerance Rehabilitation Services*
- *Early Cognitive Recovery Program*

THC · Minneapolis...dedicated to returning each patient to the most productive life possible.

THC
Minneapolis
A Subsidiary of Transitional Hospitals Corporation

621-588-2750

The Reserve Physician

Where quality medical care is desperately needed, the Armed Forces often values a good soldier more than a good physician.

By Michael J. Murray, M.D., Ph.D.

When the Vietnam conflict was affecting many of my friends' lives, I tried to enlist in the U.S. Navy but was refused because of my height. After completing an anesthesia residency, I attempted to join the Navy as a commissioned officer but was again refused. Still feeling the need to serve, I joined the U.S. Army Reserves. I have been a reservist in the 5501 U.S. General Hospital from 1986 to 1992 and in the 114th Combat Support Hospital since 1992, both headquarterted at Fort Snelling. I have been called to active duty twice, once for three months at the Brook Army Medical Center in San Antonio, Texas, during Operation Desert Storm, and more recently for four months at the U.S. Army MEDDAC in Würzburg, Germany, during Operation Joint Endeavor.

During my tenure in the Army Reserves, I have made several observations. Most recently, I've witnessed the military reserves assume an increasingly important role in the Armed Forces, as was evidenced during Operation Desert Storm and the several military operations since then in Panama, Somalia, Bosnia, and Zaire. The reservists' role has increased for two reasons.

First, with the end of the Cold War, the United States reduced the number of active duty personnel in the Armed Forces, including those trained in health care. Yet during peacetime, the military medical system still provides care for service members and their dependents and for retired military personnel, and also educates resident physicians and other allied health care providers who will, when trained, continue to meet the military's medical needs. The number of active duty medical personnel is no longer sufficient to maintain the military medical system's peacetime missions and to simultaneously respond to an armed conflict. More and more, the military must call upon medical reservists. During recent conflicts, Reserve medical forces staffed U.S. medical centers around the world and served during combat in places such as Saudi Arabia and Kuwait.

A second reason for the increasing role of military reservists, also brought about by the end of the Cold War, is the use of U.S. military forces in peacekeeping missions, such as those in Bosnia and Zaire recently. The military anticipates that reservists will be called upon ever more frequently, perhaps as often as every three to four years. The Pentagon tries to spread the burden on U.S. Reserve Forces, but it is not always successful. Some reservists have been called upon two to three times or more just in the past five years.

This trend poses a problem. While the military is relying more heavily on medical personnel in Reserve units, the number of physicians willing to join the Reserves is decreasing. Prior to Operation Desert Storm, approximately 80 percent of reserve



ILLUSTRATION BY CINDY LINDGREN

positions for physicians were filled. Today, that number has dropped to 60 percent, with future decreases anticipated.

Why aren't more physicians joining the Reserves? Physicians have some concern for their personal safety, but I don't believe they are any less patriotic than their predecessors. More significant are physicians' financial situations and the satisfaction they realize from the job they are asked to perform.

Most physicians face significant financial hardship when they are deployed. The U.S. Sailor and Soldier Relief Act protects only the jobs of employed physicians; it does nothing for physicians in solo practice or a small group practice. Physicians who own their own practice cannot cancel their office leases and lay off staff if they want a practice when they return from active duty; they must continue to pay the overhead on their office, including rent, employees, and benefits. The Department of Defense has responded to this issue with an insurance program to help physicians during deployment, but it is expensive, has many prohibitions, and requires that several criteria be met.

Another reason for the decrease in physician participation in the Reserves is dissatisfaction with active duty experience. Military physicians must meet the same standards as all other soldiers. In many commands, the ability to complete a 50-kilometer march is more important than caring for patients in a compassionate, timely fashion. Being a good soldier is valued more than being a good physician. This philosophical difference frustrates reserve physicians whose civilian environment puts patient needs first.

Also different is how the military addresses quality of care. The military focuses on improving quality by identifying the "bad apples," health care providers who aren't doing their job properly. Once the military identifies these individuals, they are counseled or, worse, reprimanded. Such an approach can seriously affect a person's career opportunities in the military.

Because of these and other experiences, few reserve physicians are willing to stay on. During my most recent deployment to Germany in support of Operation Joint Endeavor in Bosnia, more than

400 medical personnel were activated from the Midwest. Only about 150 agreed to a second four-month rotation. This group consisted of nurses and allied health personnel; none of the 70 physicians opted to stay.

Nevertheless, my commitment to improving the care that soldiers and their dependents receive during armed conflict and times of peace outweighs any negative experiences I've had. I'm also optimistic that new leadership in the Pentagon, the offices of the Surgeons Generals, and the Armed Forces will bring about necessary changes to improve the experience of reserve physicians. Unless we share that commitment, medical care for our troops will not improve. The young men and women who are willing to risk their lives to de-

A PLACE TO PRACTICE

by Douglas Clement

It's not for everyone, certainly, but the military is looking for a few good docs. Recruiters emphasize that military physicians practice medicine without worrying about overhead, insurance claims, staffing responsibilities, malpractice insurance, or other restrictions. "What I like best is knowing I'm not restricted by DRGs," proclaimed a military physician in a 1991 *Journal of the American Medical Association* Army recruitment ad.

Shorter working hours, international travel, and the reward of serving one's country also appeal to military doctors. "In Germany, I ran into a lot of people like that," recalls Lt. Col. Michael Murray, M.D., Ph.D., an ICU anesthesiologist at Mayo Clinic and past president of the Minnesota Medical Association who is in the U.S. Army Reserves. "Successful physicians in their 40s or 50s who got frustrated with the hassles of private practice, who felt that managed care was intruding more and more, joined the Army, had a fairly proscribed practice in terms of hours, were guaranteed a certain salary and the advantage of doing a lot of traveling," he says. Murray himself has done tours of duty during the Gulf War and the American peace-keeping mission to Bosnia.

Several avenues are available to medical students or physicians interested in military service.

Financial Assistance/ Scholarship Programs

The Army, Navy, and Air Force each provide financial aid for residents completing their training and to students just starting medical school. The Air Force, for instance, provides $18,770 per year, an $886 monthly stipend, and various benefits to qualified residents in selected specialties. In return, recipients are obligated to serve a year-for-year payback period as an Air Force physician. The Navy's program for students—the Health Professions Scholarship Program—covers tuition, books, and fees for medical school in return for payback service upon graduation. Army programs are similar. Students can also apply to the Uniformed Services University of the Health Sciences in Bethesda, Maryland, a joint-services medical school that enrolled its first class in 1976.

Active Duty

Practicing physicians can "go active" by enlisting directly in their chosen branch of the military, provided their specialty is needed and they meet various other requirements. In the Navy, general surgery, family practice, obstetrics/gynecology, and pediatrics are current "hot" categories. Physicians must go through an application process, credential check, physical, position assignment, and officer indoctrination school. "They don't need to go to the 'in-your-face' drill instructor indoctrination," notes Lt. Cmdr. Mike Pocker, U.S. Navy officer recruiter, "because they're not going to be in that type of environment."

Reserves

Each branch of the military has a reserve program, where persons pursuing civilian careers train one or more weekends a month with their military unit and then spend two or more weeks each year on active duty. Reserve physicians are a complement to full-time military medical departments, join up for a multiyear obligation, and receive financial compensation for their service.

fend our country and promote peace deserve the best care we can offer. MM

Michael Murray is a lieutenant colonel in the U.S. Army Reserves, an anesthesiologist at Mayo Clinic in Rochester, Minnesota, and past president of the Minnesota Medical Association.

The Army Reserve is currently seeking specialists in psychiatry, internal medicine, family practice, emergency medicine, radiology, anesthesiology, and selected surgical specialties. Fewer than 20 of the approximately 10,000 physicians practicing in Minnesota belong to the Army Reserve, according to Murray, and recruitment and retention is difficult. One reason is the financial burden. "One of the surgeons I was with during Operation Joint Endeavor in Bosnia figured it cost him $75,000 for four months," says Murray, because he not only lost income but also had to keep his practice open during his absence, paying salaries, rent, and overhead. In recruiting physicians to his unit, the 114th Combat Support Hospital, Murray explains the drawbacks as well as the advantages. "If people don't have a realistic expectation, then it's just more frustrating for them," he points out. "And then I end up doing psychotherapy when they're over there."

For further information, contact:

U.S. Air Force Medical Service Recruiting
612/854-2273
800/423-USAF (8723)

Army Health Care Recruiting
612/854-7702
800/235-8159

Navy Medical Recruitment Program
612/378-0952
800/422-1094

Uniformed Services University
of the Health Sciences
301/295-3030

Dr. Harold C. Deutsch World War II History Roundtable



TOPIC:
Saving Lives on the Battlefield:
The Combat Surgeon

WHERE & WHEN
Thursday, February 13, 7 p.m.
Minnesota History Center Theatre
Fort Snelling

SPEAKERS:
Bill McConahey, M.D.,
and Charles Aling

HOSTED BY:
The Minnesota Historical Society.
Open to the public. No charge for admission, but donations requested.

QUESTIONS?
Contact Don Patton at 612/835-7600

See page 18 of this issue for a profile of Dr. Bill McConahey.

HEALING THE WOUNDS OF WAR

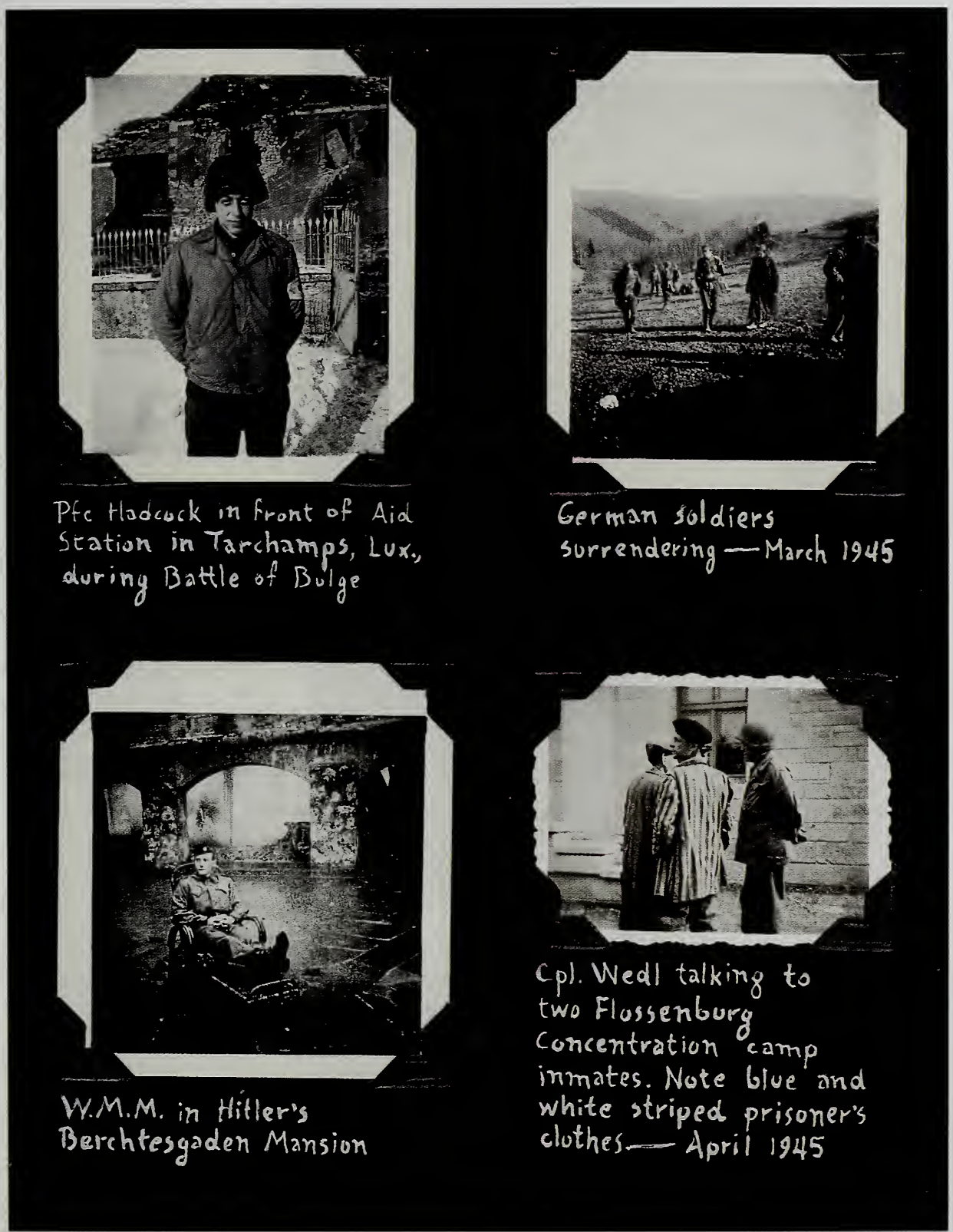
Military medicine is an ancient paradox. War, a societally sanctioned attempt to inflict massive casualties, employs physicians to mitigate its inevitable outcome. And medicine, whose first injunction is to do no harm, has advanced by experience gained during centuries of military conflict. "He who would become a surgeon," wrote Hippocrates, "should join an army and follow it."

This article profiles three men who did just that. For very different wars, in distant lands and distinct eras, these Minnesota physicians joined the military and did their best to keep soldiers—of both sides—from dying.

Bill McConahey, 80 years old, served as a combat doctor during the D-Day invasion of Normandy and the subsequent sweep of his 90th Division through France, Belgium, Germany, and Czechoslovakia. George Nemanich, 57, was a general surgeon in 1971 at a medical detachment in Pleiku in the central highlands of South Vietnam. Jeffrey Welna, 39, "went to the sand" as an anesthesiologist for two different EVAC hospitals near the frontlines of the Persian Gulf War.

Their experiences differ, by virtue of their individual circumstances and the nature of each war, but each man's story shares common threads of courage, sacrifice, and service to country. ⇨

by Douglas Clement



A page from Dr. William McConahey's WWII photo album (in above photo, W.M.M. is McConahey).

A Combat Physician on the Frontlines During World War II

William M. McConahey, M.D.

"Machine guns rattled over the next hill, burp guns ripped too close for comfort. ... We dug foxholes fast that evening, so we could stay alive in that rain of death."

This dramatic prose begins Chapter 7 of "Battalion Surgeon," Dr. Bill McConahey's account of his experience as a combat physician in the last year of World War II. In June 1944, just two years after graduating from Harvard Medical School and a year after completing his internship at Philadelphia General Hospital, McConahey was on a landing craft headed for Utah Beach in Normandy. He took the beach with his division, the 90th Infantry, marched seven miles along mined roads, and dug in for a sleepless, rainy night before a predawn attack on enemy positions, the first of many battles.

Machine guns rattled over the next hill, burp guns ripped too close for comfort. We dug foxholes fast that evening, so we could stay alive in that rain of death.

For the next year, with limited equipment, McConahey's medical aid unit attempted to patch the wounds inflicted on young men by German bombardment and infantry fire. As he reflects today, nothing at Harvard or Philadelphia prepared him for the horror of war. "I used to sit up all night as an intern taking care of some old guy with a heart attack, and here I am trying to save these guys who haven't even lived yet and they're all torn apart," he recalls. "It really got to me, in a way, but I got over it and went on."



Bill McConahey, M.D., south of Hof, Germany, April 1945.

McConahey's battalion aid station was a frontline unit, with 32 men locating, carrying, and treating casualties. "When Korea came along and Vietnam, helicopters would take [casualties] right back," he observes. "We had none of that. We hauled them back on litters." Company aid men would report the wounded men, litter-bearers and jeep drivers would bring them to the aid station, and McConahey and his technicians would treat them. He speaks with awe of the frontline men and litter-bearers. "I was amazed what a good job they did taking care of the wounded up in the front with bullets flying and shells dropping on top of them. Those guys were incredible," he says. "Their job was to get them back alive. We simply stopped bleeding, set fractures, gave out morphine for pain, and used blood plasma by the gallon."

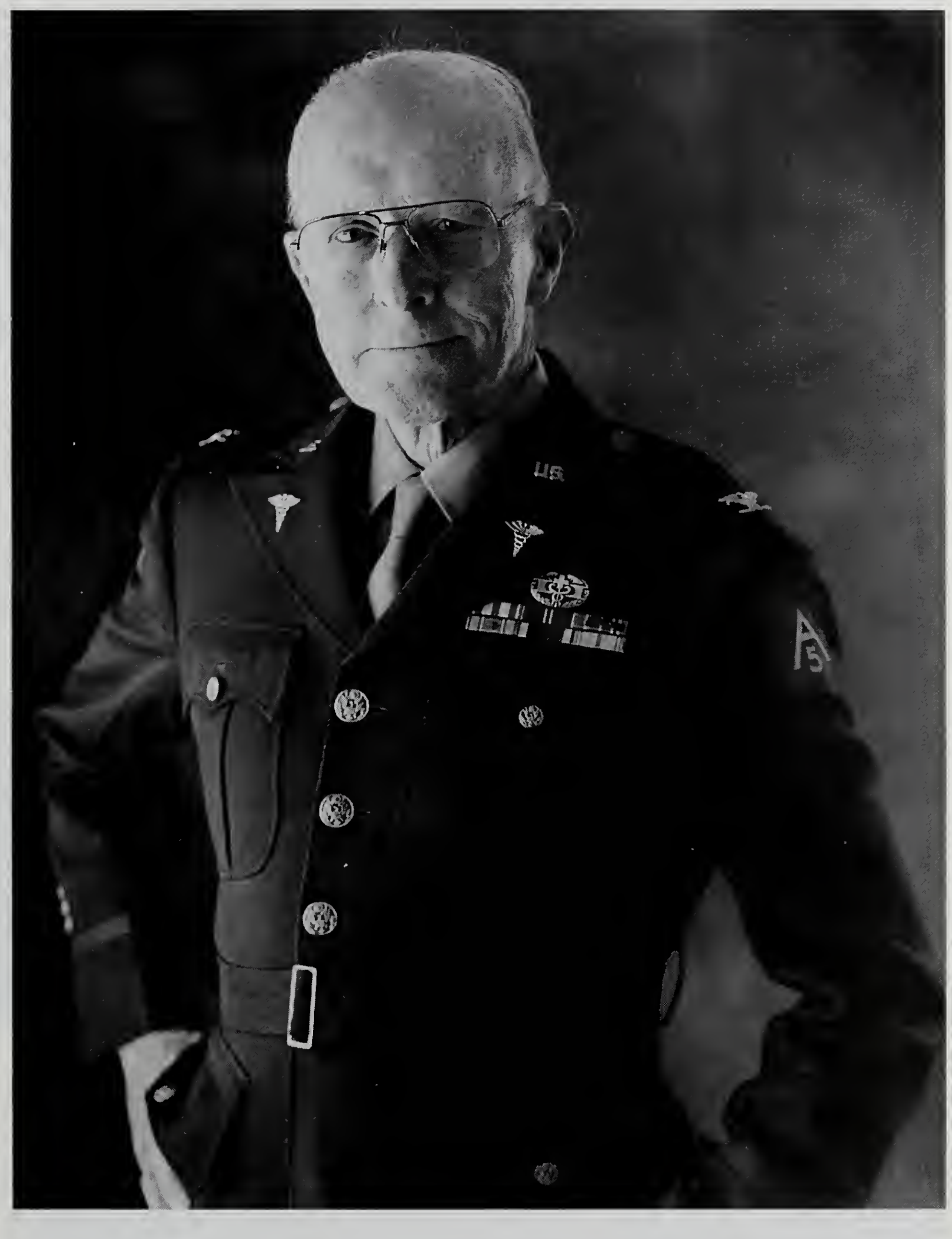
If treatment was limited, facilities were even more so. As the battalion advanced through France and Germany, McConahey used abandoned barns, old wine cellars, and occasionally chateaus as operating theaters and ICUs, and while they worked, bullets flew through windows and shot up ambulances.

The evacuation chain was simple but slow. Once patients stabilized, they were driven by ambulance to a collecting company about three miles farther back from the front and then evacuated to a clearing company about 10 miles to the rear. More seriously wounded patients went to evacuation hospitals and then to England. "I always said that if a man left my aid station alive, he made it back alive," says McConahey.

It was not uncommon for McConahey to treat German wounded, as required by the Geneva Conventions, and with the exception of the SS troops, he says he did so with equanimity. "The ordinary German *Wehrmacht* [soldier] was a decent kind of guy, and he was doing the same kind of job we were doing, because he had to," he says. "We felt, in a way, more kinship with those guys than we did with our higher echelon way back in the rear having tents and hot meals. We didn't like [the Germans] in many ways, but we didn't have trouble treating them

because they were wounded and needed care."

It's a charitable view for a man nearly killed by Germans on many occasions. Yet McConahey contends that his life was often spared because Germans saw the Red Cross painted on his helmet and armbands. Still, on August 13, 1944, the *Luftwaffe* flew over his camp in Alençon, France, with no regard for his medical training. "I lay helplessly on the ground under a tiny tree," writes McConahey in "Battalion Surgeon." "One of the bombers released a bomb over me. I heard its high-pitched whistle as it hurtled down. ... The whistle became a scream, and I opened my mouth and braced myself for the concussion. There was a dull thud and that was all. The bomb had hit very close, but it was a dud. ... The rest of the night was quiet, so I slept soundly."



PHOTOGRAPH BY JOHN NOLTNER

The courage to continue in the face of fear is something McConahey explains simply. "Of course, everybody is scared," he says. "The question is, could you do your duty? I remember going over on the ship and thinking, 'Now, can I really live up to honoring my country and my family and my wife—can I really do all this?' But once you get there, and things are popping all around you, you just do it automatically; you forget about it, you act."

And ultimately, he'd encourage others, indeed, his own children, to serve their country in war. His daughter and two sons haven't had to serve in the military, and, on one hand, he prays they won't. "When I was there I thought, 'I hope I'm doing this so that my kids will never have to.' But I think if it comes down to their doing their duty, yes, I think they should. I would recommend it, urge it."

McConahey came home in October 1945, started a fellowship in internal medicine at Mayo Clinic in 1946, and served on staff for 37 years, specializing in endocrinology. He never suffered serious posttraumatic stress, though he had a few bad dreams and would occasionally mistake a car's backfire for incoming artillery. And his return to civilian life was very positive; many of his colleagues at Mayo were also veterans, and they had a shared enthusiasm for getting on with their lives.

He argues that his experience serving in the war changed his life forever, not by altering his medical interests but by teaching him the importance of serving others. "It taught me that what counted in life was what you could do for others—not to become the biggest shot in town, not to have the most money in town, not to be the most powerful guy, but simply to do what you could for your society, for your family and your friends, and to live your life as well as you could." ⇨

A "MASH" Unit Surgeon in Vietnam

George J. Nemanich, M.D.

A small naval clash was reported off the coast of North Vietnam in August 1964. Today, historians argue whether the skirmish actually occurred, but half a world away, at St. Mary's Medical Center in Duluth, Minnesota, intern George Nemanich soon knew the alleged incident would change his life. The Tonkin Gulf Resolution, passed by Congress on August 7, became the legal basis for a war that would last a decade, topple an American president, and kill hundreds of thousands of soldiers and civilians.

"There was a great scramble among all of us as to how to deal with this as we were emerging into our medical careers," recalls Nemanich. Some medical students joined the Reserves, a few volunteered for the public health service, others were drafted, and still others evaded the draft. "And then there were those of us who got into deferment programs to do a residency. That's what I finally chose." Nemanich joined the Army.

He began a five-year surgical residency at the Veterans Affairs Medical Center in Minneapolis and, when he finished in July 1970, was assigned to the Valley Forge Army Hospital in Pennsylvania. "It was a good experience in a number of ways," he recalls. "I had a young family, three kids at that time. It gave me more time to be with them because the Army base was much less frenetic than my surgery residency program." But not for long. "In the spring of 1971, on Good Friday, of all days, I got my orders for Vietnam. It's a day you never forget."

Nemanich's wife and children returned to Duluth. He flew overseas. Elections were scheduled in South Vietnam for November, and the Army expected the North Vietnamese to disrupt them. Nemanich was one of a number of surgeons flown in to care for the anticipated casualties. He was assigned to a hospital in Pleiku, in South Vietnam's central highlands, next to the headquarters of the First Cavalry Division, an air mobile unit whose helicopters flew missions throughout the country.

In 1972, people didn't want to think about Vietnam. It was certainly not a good time to be associated with the war—no warm fuzzies, no ticker-tape parades.

The hospital was once a large evacuation facility, but by 1971 it had been decommissioned. When Nemanich arrived, it was a small medical detachment. He was the only surgeon, working with a partially trained anesthesiologist, a few general medical officers, and "a fellow with a couple years of internal medicine under his belt," recalls the surgeon. "And that's it. It was sort of like a little MASH unit."

But the facilities were comprehensive and up-to-date. "We had four very modern operating rooms, very much like anything you'd walk into in a Twin Cities hospital," says Nemanich. "We had x-ray machines that were comparable with anything I used back home." They used the old ICU's 30 beds for their patients, and the seriously sick were flown to larger hospitals in Da Nang.

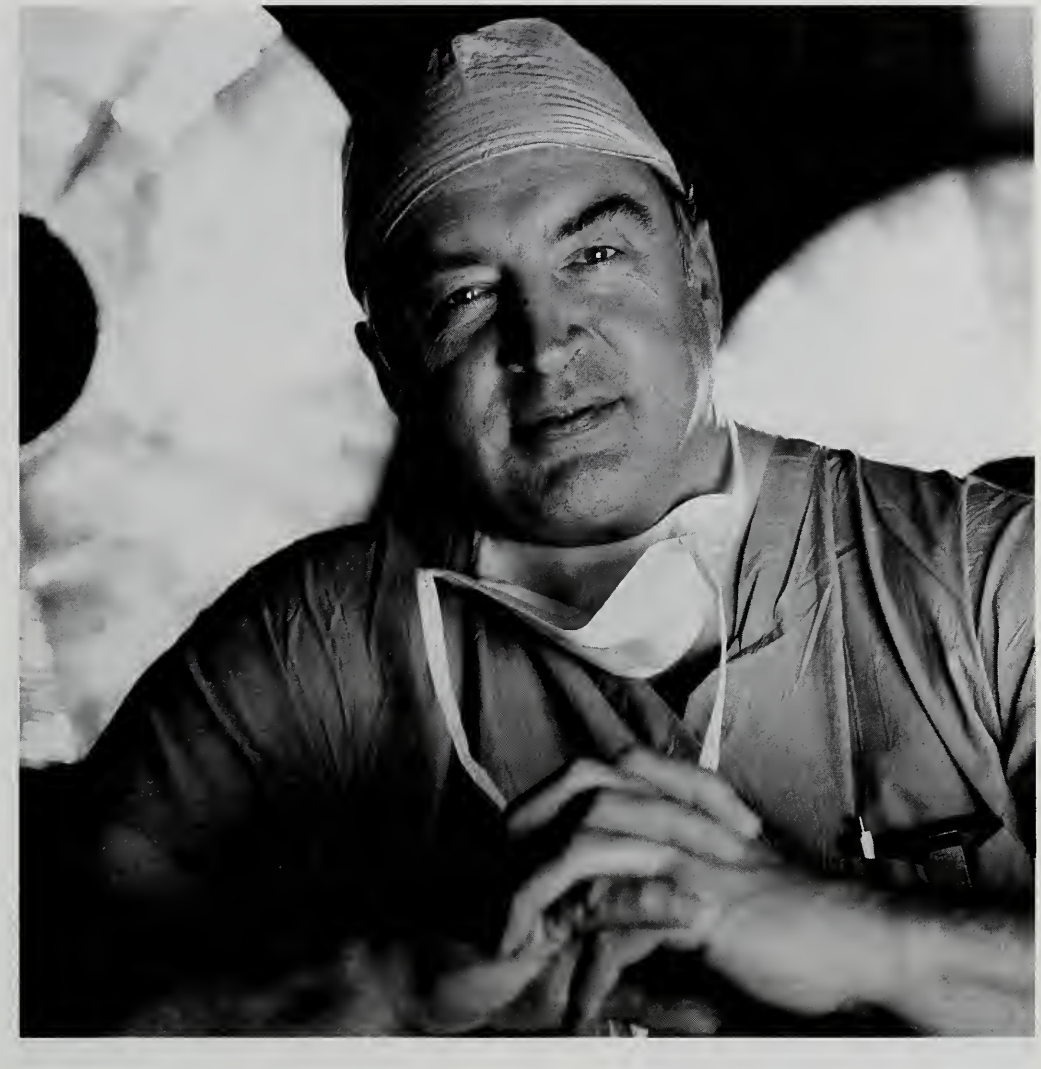
Surprisingly, Nemanich and his unit saw little action. "Actually," he says, "it was somewhat boring. I think people have a view of being in the military in a war zone as guns firing off at all times and always walking around wearing a flak jacket. That wasn't the case at all."

The national election was peaceful, and his "MASH" detachment had fewer casualties than expected. "There was not a



George Nemanich, M.D., in Pleiku, Vietnam, 1971.

lot of firefighting," notes Nemanich. "We took care of a lot of accidents, an occasional gunshot wound or helicopter crash victim, that type of thing." One of the more interesting patient groups was the Montagnard, a mountain people of South Vietnam, who suffered a high incidence of goiter. "We did a lot of thyroid surgeries to fill in the time."



PHOTOGRAPH BY JOHN NOLTNER

Still, admits Nemanich, who now practices general surgery in the Twin Cities with Surgical Consultants, P.A., life in Pleiku wasn't as placid as life back home. "Of course, there were times when the VC [Viet Cong] were bringing down rockets and firing at us and knocking out our buildings," he recalls. "That was a little scary because there was no predicting where the darn rocket was going to land." On one occasion, Viet Cong rockets knocked out the electricity, but their greatest worry, according to Nemanich, was that "we couldn't get Armed Forces Radio for the Monday night football scores."

So was it like "M*A*S*H," television's sitcom version of war? Not at all, says Nemanich. "M*A*S*H" depicts casual medical practice, under less than sanitary conditions. "In Pleiku, there was good sterile technique with no major compromise in care." Nonetheless, there were parallels. "We were in a smaller unit, and there was a lot of camaraderie. We had a flag football team, and we planted a garden." And they bet on the Vikings.

Nemanich had just a six-month stay in Vietnam. "The greatest Christmas present I ever got," he says, "was a call from Da Nang asking me where I'd like to go in the United States if I got reassigned. I said, 'As close to Duluth as possible.' "

Nemanich came home for Christmas, but the nation showed little warmth for Vietnam's veterans. "In 1972, people didn't want to think about Vietnam," he says. "It was certainly not a good time to be associated with the war—no warm fuzzies, no ticker-tape parades."

The war changed the surgeon, too. "I was in the military for two years, and I was in Vietnam for about six months," says Nemanich. "I came to abhor war and all that it represents." He recounts the story of a medevac helicopter pilot, also from Minnesota, who went out on one last rescue mission and was killed. "What a waste; two more weeks and he would have gone home. That's the kind of tragedy of war that you hate, the waste of life."

Nemanich won't advocate the combination of medicine and war to his children, one of whom is an orthopedic resident at Mayo Clinic, and another, a premedical student. "I would advise them as strongly as possible to avoid being in the Reserves. The reason is simple: you can't predict what the future holds." ⇨

A K-team Commander in the Gulf War

Jeffrey O. Welna, M.D.

"I got into the Reserves when I was finishing my residency training," recalls Jeffrey Welna, M.D., an anesthesiologist at St. Marys and Methodist hospitals in Rochester. "And I did it for a very simple reason: I was just flat broke." In 1987, the father of two young children found that the Army wanted his skills and would double his income. "It really was the difference between generating enormous debt or staying even."

He joined at the rank of captain and spent one weekend a month and two weeks a year at various Army bases. Eventually promoted to major, he was given command of a "K-team," a three-person anesthesia team.

In August 1990, while at a professional meeting in San Francisco, Welna heard the news: Iraq had invaded Kuwait. By Thanksgiving, he and his unit were activated. Three weeks later, Welna's K-team was on a C-141 military transport headed for Saudi Arabia.

Welna describes those first days as a "complete nightmare," replete with classic military snafus: an airplane that leaked fuel all across the Atlantic, fixed "by a big wad of stuff that looked like bubble gum"; a medical brigade that forgot to meet them when they landed in Dhahran; a Combat Support Command that wouldn't give them tents; the "requisitioning" of a few tents from a flatbed truck in the middle of the desert while its driver was taking a shower; the Army's appropriation of one of Welna's two anesthesia machines; and near fistfights in chow lines between surgeons who'd been operating all night long and mess hall authorities who insisted they weren't wearing appropriate clothing. "Typical kinds of military nonsense," says Welna.

But all that paled next to harsher realities. For his first month, Welna was stationed with the 12th EVAC Hospital barely 30 miles from Iraq. "There was very little between us and them," says Welna. "It was an uncomfortable feeling to show up and be told the Iraqis have moved another division or brigade of the Republican Guard in just across the border. Being type A people, one of the worst things to do is to put you someplace, rattle you up a little bit, and then give you absolutely nothing to do except wait for the patients. And then be told that, well, we could see none or as many as 5,000 in 24 hours."

It was an uncomfortable feeling to show up and be told the Iraqis have moved another division or brigade of the Republican Guard in just across the border.



Jeffrey Welna, M.D., in Kuwait, 1991.

The 12th EVAC, the first evacuation hospital established in the country, consisted of Deployable Medical Systems (DEPMEDS), a quickly erected system of long, low, nylon tents, completely unlike the impromptu aid stations that McConahey used and the concrete and steel hospital that Nemanich worked in. It was high-tech but not foolproof. "Bugs got in and dust blew in," says Welna, "so keeping the place clean [was difficult]. We did all sorts of stuff we wouldn't even conceive of here. I mean, a fly in the operating room here? People would have a meltdown! A fly in the OR there was routine." One of the K-team's responsibilities was to wield the fly swatter that hung from a hook near the IV fluid.

At the same time, technology was available that McConahey and Nemanich could only have dreamed

of. "Thankfully, we had one of the first mobile CT scanners," recalls Welna. "And while we were there, a young guy in his 30s or early 40s herniated a disk in his back and ended up with severe neurologic problems." With the CT scanner, surgeons could perform a laminectomy on site.

Most of Welna's work was more mundane. Broken bones, foreign objects in eyes, appendicitis, "and tons and tons of motor vehicle accidents."

Fortunately, there were few Allied casualties to be treated by the roughly 3,000 physicians (and 43,000 other medical personnel) employed by the U.S. military in the Gulf War. Of the 540,000-member U.S. force, 148 were killed in action and 458 were wounded. On the other hand, there were tens of thousands of Iraqi prisoners of war, and when Welna was transferred to the 13th EVAC, he ended up treating many. Like McConahey, he had little trouble helping the average foot soldier. "It was just a steady stream of poor, hungry, miserable-looking men who needed the care, if not as much as our guys did, even worse."



PHOTOGRAPH BY JOHN NOLTNER

Welna has no doubt that he was altered by his wartime experience. "My career has changed to a certain extent," he reflects. "I now have a little more input into trauma issues, having been there, done that." And being in the military has possibly made it easier to obtain security clearance to work with Mayo Clinic's VIP patients.

But the deeper changes are personal. "Going away [gives you] a whole different perspective, knowing that you may not come back," says the anesthesiologist. As was true for Nemanich and McConahey, leaving a wife and children behind was traumatic for Welna. "It was awful," he recalls. "Thankfully, we had some good support." And the possibility of imminent death from an attack by Iraqi forces gathering 30 miles away was frightening and depressing. "If push came to shove, we were dispensable kinds of assets," says Welna. "That's a difficult thing to face. I was 32, 33 at the time, and looking at my career really starting to blossom here, and then looking right at the fact that I might end it. I don't mean this in a maudlin way, but we all had to confront that beast."

On the other hand, Welna "took a lot of pride and solace in the fact that we were there doing the job for the kids that really didn't know what the hell they were getting into, a whole lot of 18-, 19-, 20-year-olds who thought, man, they were going to go fight the great one, and who got all busted up and didn't understand that this was part of the deal—that somebody was going to die. We all did a lot of growing up there." MM

Doug Clement is a free-lance writer in Minneapolis, Minnesota.

The Changing Face of the Veterans Affairs Health Care System

After five decades, the U.S. Department of Veterans Affairs health care system is restructuring the way it operates to address managed care issues and to better serve its patients.

Kenneth W. Kizer, M.D., M.P.H.

Few entities today are at the nexus of as many forces of change as the Veterans Affairs health care system (VA*). Powerful societal and industrywide dynamics are fundamentally changing an organization that recently celebrated 50 years of service. In response to these dynamic forces, the VA has transformed its hospital system into 22 integrated service networks and is shifting its primary focus to ambulatory care. Although the number of its patients has increased, the VA has decreased its admissions by more than 100,000 and reduced its bed days of care by 32 percent in the last two years. The number of ambulatory care visits has increased by 4.5 million. In addition, the VA has implemented improvements in customer service standards, increased the number of patients enrolled in primary care from less than 20 percent to over 70 percent, and eliminated almost two-thirds of its paperwork. Amid these dramatic changes, the VA has maintained its dedication to medical education and research.

Forces Affecting the VA

A number of forces have led to the unprecedented changes within the VA health care system. As the second largest agency in the federal government, the U.S. Department of Veterans Affairs often finds itself at the center of conflicting views about the role and size of government. Many questions arise. In a country where health care delivery is primarily a private-sector function, should the federal government be in the business of directly providing health care? Who should be eligible for special veterans benefits, and at what level? How much should the government spend for veterans hospitals and other capital assets, and should these be exclusively for the use of veterans, especially as the future (at least as currently projected) portends fewer veterans?

In addition, as the nation's largest integrated health care system, the VA is directly affected by managed care, which is revolutionizing the way health care will be provided in 21st century America. The VA is like thousands of other health care organizations throughout the nation that must restructure to meet the demands of managed care.

As a direct provider of health care, the VA also must confront the increasingly rapid explosion of biomedical, scientific, and technological knowledge that is dramatically expanding the ability to treat injury and illness. Through myriad technological and scientific advances, such as those from the Human Genome Project, medicine is advancing at an unprecedented rate.

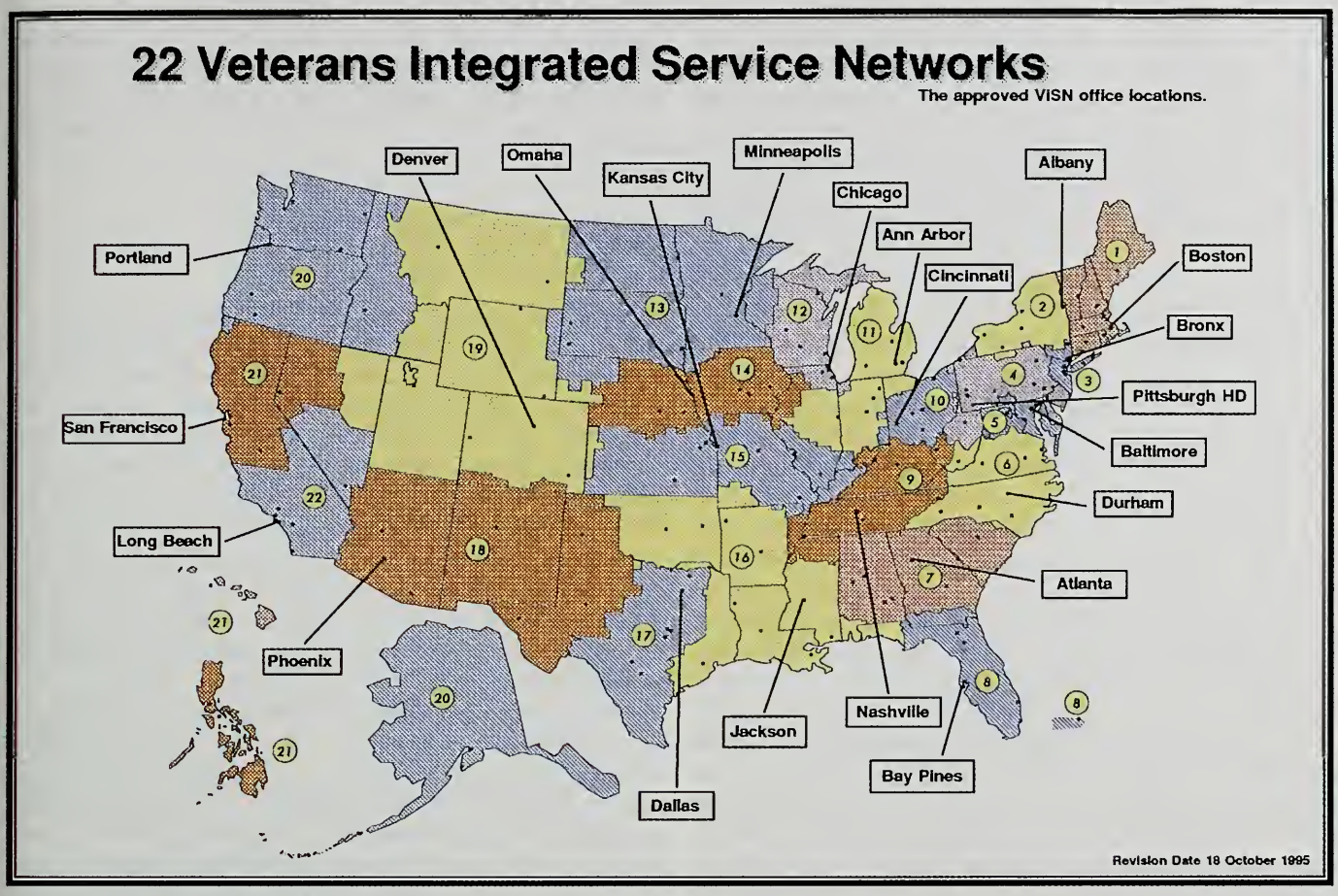
An additional force affecting the VA is America's changing demographics, and the aging of the population in particular. The veteran population is about a decade older than the national average, and the VA's efforts to provide medical care and social support services for elderly persons is providing valuable experience for the nation.[1]

Organizational Reengineering

Historically, the VA—patterned after what was considered the best of American health care for most of the latter half of the 20th century—emphasized medical specialization, high technology, and acute inpatient services. Its approach to providing health care was often geared toward accommodating the hospital, physician, or other service provider, rather than the patient, and focused on individual components of care without connecting the various services or service providers. This design left patients to negotiate the maze of services on their own, resulting in fragmented care, less than optimal outcomes, and unaffordable costs. As health care becomes ever more technologically sophisticated, an overarching organizational structure is necessary to help patients as well as health care providers efficiently and effectively utilize services. Recognizing this, much of the restructuring of the American health care system today is aimed at establishing organized or integrated care systems.

The VA has initiated a restructuring characterized as far-reaching, innovative, and "unprecedented."[2] Fol-

*In this article, "VA" refers to Veterans Affairs health care system.



Figure—The boundaries of the new Veterans Integrated Service Networks.

lowing various policy changes and planning efforts begun in late 1994 and early 1995, the VA created a new organizational structure in October 1995 that consolidated its 172 independent and often competing hospitals, approximately 400 clinics, 131 nursing homes, over 200 counseling centers, and various other facilities into 22 integrated service networks.† (See also the Face to Face article, page 8, which profiles the director of the VA's Upper Midwest Network.) The boundaries of these new Veterans Integrated Service Networks, or VISNs (see the figure above), were based on existing patient referral patterns; aggregations of sufficient numbers of patients and treatment facilities to allow for a continuum of primary, secondary, and tertiary care; and, to a lesser degree, political boundaries such as state and county jurisdictional lines.[3]

Integrated systems of care strive to manage the health services delivery process as a whole, providing a continuum of coordinated professional and support services in a cost-effective manner. The shift to VISNs should lead to improved clinical outcomes, lower costs, and increased patient satisfaction, especially for patients with complicated or chronic conditions—and no system has more such patients than the VA. In addition, patients should benefit from the heightened emphasis on health promotion and disease prevention that is intrinsic to integrated health care systems.

The VA's new operating structure emphasizes efficiency and productivity, and it aims to eliminate unnecessary bureaucracy, flatten administrative structures, and streamline communications. Implementing the VISNs and concomitantly restructuring VA headquarters alone resulted in administrative savings of about $18 million per year. The new structure also decentralizes day-to-day decision-making, a radical departure from the VA's historically centralized and hierarchical command.

VISNs also promote a new culture of collaboration and cooperation predicated on the need to optimize health care value.[4] They encourage pooling resources and coordinating services. For example, since mid-1995, the VA has merged the management and operations of 34 medical centers into 14, producing an estimated $26 million initial annual savings, which is being redirected from administrative to clinical services. A portion of this money has been used to support 46 new community-based outpatient clinics that have been developed since the end of 1995. The VA expects even greater savings at the merged facilities as they become more fully integrated over time. The merger of the management and clinical services of additional medical centers is in various stages of planning.

The VA's new network-based operational structure aligns resources around patients instead of treatment

†An integrated service network is defined as a group of treatment facilities and support services organized to collaboratively deliver health care services to a defined population.

facilities, professional disciplines, or administrative structures. Personnel who provide direct patient care and those who support the provision of patient care work as teams within strategic health care groups‡ that are being increasingly organized according to service lines§ that more closely reflect patient needs. Indeed, much of the reengineering underway in the VA today is predicated on a fundamentally different way of thinking about health care.

A Shift to Ambulatory Care

Another change within the VA is the shift from a bed-based, specialty-driven system to one rooted in ambulatory care, where primary care is the norm. Although the total number of VA patients has increased about 4 percent since 1994, acute care hospital admissions have dropped 12 percent, from 940,043 at the end of 1994 to 837,275 at the end of 1996. During these two years, the VA's acute care average daily census declined 22 percent, from 39,941 to 31,529. Outpatient visits increased 18 percent, from 25.4 million to 29.9 million. The number of acute care operating beds decreased 17 percent by the end of September 1996, from 52,192 to 44,688.

A further measure of success resulting from the shift to ambulatory care is seen in the VA's rate of bed days of care (BDOC) per 1,000 users. Systemwide, the VA's BDOC went from 3,527 per 1,000 at the end of 1994 to 2,525 per 1,000 at the end of 1996, a 32 percent decrease. This compares with an average annual drop of 3 percent in the preceding five years. The VA's BDOC is now only slightly higher than that of Medicare, although VA patients have a considerably higher disease burden and are markedly more socially disadvantaged. The Veterans Affairs Medical Center in Minneapolis offers a good example. Originally opened in 1988 with 735 operating beds, VAMC Minneapolis now operates about 300 acute care beds and will probably reduce that number to about 200 within the next two to three years.

Clearly, tertiary care hospitals like VAMC Minneapolis will always have a place in the VA, but primary care is the logical foundation for any health care system of the future.[5] In the last two years, the VA has increased the proportion of its patients enrolled in primary care from less than 20 percent to more than 70 percent. Universal primary care should be in place in 1997. As a result of merging facilities, shifting to ambulatory and primary care, and other changes, VA staffing has declined 6 percent from 237,022 in 1994 to 223,646 at the end of 1996.

Savings from Negotiated National Contracts

The VA has also started to use its purchasing power as one of the largest health care systems in the country to leverage better prices for the myriad goods and services it uses. A "Commercial Practices Initiative" launched in 1995 has begun to produce substantial savings. For example, contracts signed at the end of 1996 for the two H_2 blockers cimetidine and famotidine will save $25.9 million over 1995 costs for these drugs. Another contract for several high-volume generic drugs is generating $10.8 million in savings. Contracts for wheelchairs, needles, and syringes will save about $2.5 million. Several other pharmaceutical contracts under negotiation should save nearly $130 million.

An innovative multistate nursing home contract promises additional savings. The VA contracts for private nursing home care for approximately 9,000 long-term care patients on any given day. (These patients are in addition to approximately 15,000 long-term care patients in VA nursing homes and about an equal number in state veterans homes.) Previously, the VA negotiated some 3,200 contracts facility by facility for care of these patients. Under a new single, multistate contract, seven different providers covering 43 states will offer most of this contract long-term care. The new contract allows for increased access by adding 600 private nursing homes not previously available for VA contract care, and it allows for improved quality by specifying quality assurances in the contract (e.g., a provider's entire contract is at risk if the quality of care at one facility becomes unacceptable). This new contract is expected to save tens of millions of dollars over the next three years because of reduced administrative costs and lower daily rates.

Eligibility Reform

Another important new development affecting VA operations is eligibility reform legislation enacted in 1996. In the past, congressionally mandated eligibility rules biased VA care toward inpatient treatment. After nearly a decade-long debate, these rules were finally changed. The new Veterans Health Care Eligibility Reform Act of 1996 gives equal weight to VA inpatient and outpatient care and gives the VA flexibility to enter into partnerships with private-sector and other health care providers.

Customer Service

As part of the VA's top-to-bottom overhaul of how it provides care to its 3 million patients each year, the VA is also focusing more on customer service. In 1994, the

‡A strategic health care group (SHG) is defined as a multidisciplinary group organized to deliver a continuum of care to a defined population or care in a specific setting. The SHG integrates data, skills, and best practices into systemwide policy, planning, and service delivery by developing clinical guidelines, critical pathways, practice parameters, and outcome expectations.

§Service lines link treatment facilities, caregivers, clinical services, and administrative support for a particular type of patient or service. This linkage permits sharing of resources, ideas, and information and strives to improve access, enhance quality, optimize efficiency, and maximize service satisfaction.

VA implemented its first-ever customer service standards, and patient surveys in 1995 and 1996 showed statistically significant improvements since adopting these standards. Overall, 65 percent of patients rated the VA's care and service as "very good" or "excellent" in 1996, up from 60 percent in 1995; 55 percent of patients said in 1996 they would "definitely return" to the VA for care, compared with 49 percent in 1995. In addition, patient complaints and dissatisfaction significantly decreased.

Besides implementing standards for waiting time, courtesy, and other elements of service, the VA is also introducing a "semi-smart" universal veterans identification and access card. Previously, each hospital had its own registration process. Similarly, in its efforts to reduce paperwork, the VA has eliminated 2,626 of its 4,074 forms, a 64 percent reduction, in the past two years. All forms and directives have been automated and placed on CD-ROM.

Although the VA has not yet reached the level of "five-star" service for which it is aiming, it is improving. Under its new performance contract management system, VA senior management is being held accountable for achieving substantially improved results in service satisfaction.

Education and Research Commitment

Amid dramatic changes in how it provides medical care, the VA has maintained its commitment to education and research. Indeed, the future of veterans health care and academic medicine are closely linked.

In its 50 years of service, the VA has assumed a major role in health professional training. Starting with two medical school affiliations in 1946, with the University of Minnesota and Northwestern University, the VA has gone on to become the largest provider of graduate medical education in the nation. Now, 130 VA hospitals are affiliated with 105 of the nation's 125 medical schools, and the VA funds more than 8,900 medical residency positions each year (about 10 percent of the nation's graduate medical trainee positions). Some 34,000 residents rotate through the VA's residency programs annually, and about 22,000 medical students complete a portion of their clinical training at VA medical centers each year. Today, more than 60 percent of doctors in the United States have received all or part of their training at VA hospitals.

In addition to being the largest provider of graduate medical education, the VA is the largest single provider of other health care professional training in the country. More than 40 different types of associated or allied health care professionals are trained at VA medical centers through affiliations with more than 1,000 universities, colleges, and other institutions of higher education. Nearly 50,000 nurses, podiatrists, optometrists, physical therapists, and other health care professionals pass through these programs each year.

While the VA's commitment to education remains firm, changes are underway. For example, starting in academic year 1997-98, the VA will begin to shift the types of residencies it offers. Based on the recommendations of the Under Secretary for Health's Residency Realignment Advisory Committee, chaired by Robert Petersdorf, M.D., the VA will eliminate 250 resident positions and transition 750 specialist or subspecialist residency positions to primary care positions over the next three academic years.[6] This shift will return VA-funded residency positions to the 1987 level and will increase the proportion of VA residencies in primary care (mostly general internal medicine) from the present 37 percent to 49 percent. VA training increasingly will take place in clinics and other outpatient settings, in keeping with the shift to ambulatory care.

The VA's commitment to research also remains strong. After several years of a declining research appropriation, the last two VA budgets have reflected a modest funding increase. Similarly, the VA has pursued several new partnerships to increase research opportunities, since large increases in the congressional research appropriation are no longer realistic. One example is the VA's partnership with the Juvenile Diabetes Foundation; JDF will match dollar-for-dollar the VA's funding for "bench-to-bedside" diabetes-related research. The funds will support VA investigators at five new Diabetes Research Centers of Excellence at VA medical centers. In another case, the VA recently signed an Interagency Agreement with the National Cancer Institute (NCI) that will significantly increase the opportunity for VA investigators to participate in NCI clinical trials and will also increase the availability of state-of-the-art cancer treatment for VA patients.

Conclusion

The VA can be proud of the care it has provided to millions of Americans over the past 50 years, as well as its contribution to biomedical science and the training of health care professionals. Now, through its reengineering efforts, the VA is striving to become a patient-focused health care system that provides "the right care at the right time in the right place for the right cost."[4] So far, the effort is resulting in easier access to patient care, more predictable and consistent service availability, and greater responsiveness to local needs. By building on its strengths, such as its 50-year partnership with the University of Minnesota, by embracing change, and by remaining flexible and open to rethinking, reevaluating, and redesigning all that it does, the VA can adapt and thrive in the future. MM

Acknowledgment

Adapted from a presentation to the Minneapolis Veterans Affairs Medical Center's continuing medical education symposium held September 28, 1996.

Kenneth Kizer is the under secretary for health at the U.S. Department of Veterans Affairs in Washington, D.C.

continued

REFERENCES

1. Kizer KW. Geriatrics in the VA: providing experience for the nation. JAMA 1996;275:1303.
2. General Accounting Office. VA health care: substance abuse treatment programs serve psychologically and economically disadvantaged veterans. Washington, D.C.: General Accounting Office, 1996. Report No. GAO/HEHS-96-204.
3. Kizer KW, ed. Vision for change: a plan to restructure the veterans health administration. Washington, D.C.: U.S. Department of Veterans Affairs, 1995.
4. Kizer KW. Prescription for change. Washington, D.C.: U.S. Department of Veterans Affairs, 1996.
5. Institute of Medicine. Primary care. Washington, D.C.: National Academy Press, 1996.
6. Petersdorf RG, ed. Recommendations of the Residency Realignment Advisory Committee. Washington, D.C.: U.S. Department of Veterans Affairs, 1996.

PHYSICIAN INTERNAL MEDICINE

Move to St. Cloud, Minnesota and join the Internal Medicine practice of *WARREN H. LUEDTKE, M.D.* He is the sole physician in a well-established, independent clinic. Specialties of the practice include *INTERNAL MEDICINE AND PRIMARY CARE.*

Dr. Luedtke is a Member of The Minnesota Clinic, Central Minnesota's only physician owned and governed medical delivery system. The Minnesota Clinic exists to continue cost effective, quality health care through the private practice of medicine.

Consider the benefits of a well-established practice and the pleasures and practicalities of life in a small city on the Mississippi, flourishing with cultural, civic and family activities.

TO FURTHER EXPLORE A GREAT MOVE, CALL:

WARREN H. LUEDTKE, M.D.
108 DOCTOR'S PARK
ST. CLOUD, MN 56303
(320) 255-1799

MEMBER OF THE Minnesota CLINIC
Your Partner in Quality Health Care

Affiliated COMMUNITY *Medical Centers, P.A.*

Join the security of a large multispecialty group located in Southwest and West Central Minnesota Communities of 3,700 to 19,000. All areas flourish with four-season recreational opportunities, strong economies and excellent education where family and lifestyle are a priority. Outstanding benefits for BE/BC physicians in:

Dermatology
Family Practice
General Surgery
Internal Medicine
Neurology
Ob-Gyn
Orthopedic Surgery

Contact: Janiece Durham
Physician Recruitment Coordinator
Affiliated Community Medical Centers
101 Willmar Avenue SW
Willmar, Minnesota 56201-3591
320-231-6366

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 25 member medical staff has openings in the areas of:

Family Medicine
Orthopedic Surgery
OB/GYN
General Surgery
Psychiatry
Podiatry

CHISAGO HEALTH SERVICES
A subsidiary of Fairview

Please contact:
Physician Recruitment and Retention Department
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454
1-800-842-6469

Posttraumatic Stress Disorder Among Veterans

PTSD is a complex syndrome, but research involving veterans is broadening our understanding.

Michael E. Dieperink M.D., Ph.D.

Mr. A is a 47-year-old who reports an ordinary childhood and adolescence. He was drafted into the army at age 18 and fought in the Vietnam War. After returning to the United States, he worked in a factory. He never spoke to anyone about his overwhelmingly traumatic combat experiences. Mr. A married five years later and subsequently had two children. His family routinely spends the holidays with his in-laws, but, despite the festivities, he feels little kinship and finds himself detached from his surroundings. Prior to losing his job, he avoided social contact at work and currently has no friends. In his opinion, no one understands him. The thought of other than superficial interactions with people makes him very uncomfortable.

Beyond Mr. A's reserved exterior exists a tumultuous, almost parallel life that expresses itself particularly at night. His sleep difficulties started almost as soon as he returned from Vietnam and have increased in intensity. He often lies awake worrying about falling asleep and what sleep will bring him. When he does sleep, he is tormented by nightmares of particularly traumatic events in Vietnam that appear so real he can smell and taste his surroundings. Several times per month nightmares wake him, and the sheets are soaked with sweat. He thrashes about in bed and twists the covers into knots, and his wife frequently must sleep on the living room couch. Noises that would not wake most people keep Mr. A awake for the entire night. He spends these hours staring out the kitchen window looking for intruders along the perimeter of his property.

Thoughts of Vietnam also trouble Mr. A during the day. Traumatic events replay in his mind, regardless of what he would like to think about. He always feels on edge. An unexpected, loud noise startles him more than it would others. When planes or helicopters fly by, a chill goes down his back, his chest tightens, and his heart pounds. Sometimes, when the thoughts become overwhelmingly persistent, Mr. A goes to the local bar and drinks beer until the thoughts go away. This escape is temporary; after a while, the thoughts return.

Two years ago, Mr. A became irritated with his boss and impulsively quit his job. Since then, he has not been able to find steady employment, although he maintains some income from odd jobs. He has become increasingly isolated, rarely leaving the house. As Mr. A withdraws more and more, his wife grows less supportive.

Historic Overview of Research

Mr. A is fictional but typifies some patients who come to Veterans Affairs hospitals for care. Researchers have long recognized the psychological effects of war on military personnel and have used this combat experience to study the effects of extreme stress. Indeed, a good deal of what researchers know about response to psychological trauma has come from studying veterans from the Civil War to the Persian Gulf War.

U.S. Civil War

During the U.S. Civil War, Da Costa investigated 300 soldiers who had a war syndrome he called irritable heart,[1] which was characterized by fatigue, headache, diarrhea, dizziness, and sleep disturbances. Few of the veterans had identifiable physical illnesses. Da Costa believed that about one-half of the cases were due to infection; the other cases he attributed to the stress of war. Da Costa's description makes determining specific diagnoses difficult using today's terminology.

World War I

A similar syndrome developed in soldiers during World War I and was known alternately as the Da Costa syndrome, the effort syndrome, soldier's heart, or shell shock. The variety of names reflects the confusion about the etiology of the symptoms. Researchers developed programs during World War I to determine the causes and treatment for this syndrome. At the beginning of the war, researchers understood the syndrome to have primarily physical underpinnings. By the end of the war, studies indicated psychological causes.[2] In addition to the Da Costa syndrome, awareness of an acute combat stress reaction grew. Symptoms include breakdown in battle, dazed or detached demeanor, exaggerated startle

response, and severe anxiety.[3] Researchers made two important observations about the acute stress reaction. Soldiers who were cared for near the frontlines recovered more readily than those treated at a hospital away from their combat units. Also, soldiers who were told the symptoms were due to a physical condition, particularly heart disease, were less likely to return to the front than those who were treated as if their symptoms were a normal response to extreme stress.

World War II

World War II renewed interest in the psychological effects of combat. Researchers better delineated the acute stress reaction, known as battle fatigue or combat exhaustion. Mental health professionals started describing symptoms in patients suffering from what they termed "combat neurosis."[4] Symptoms include restlessness, aggression, depression, memory impairment, nightmares, phobias, and suspiciousness. The medical field increasingly recognized that a chronic form of this syndrome existed. At a 15-year follow-up, veterans exhibited psychopathology involving aspects of the syndrome.[5] Researchers found that the syndrome was not confined to combat veterans, but also occurred in approximately one-fifth of former prisoners of war.[6]

Korean War

Studies of Korean War veterans found a similar clinical composite. For example, 23 of 42 wounded combat veterans experienced "startle reactions, occasional combat dreams, slight stammering, and other evidence of tension."[7] Researchers studied the chronic form in greater depth in both combat veterans and POWs.[8]

Vietnam War

Clinicians applied previously learned preventive measures to counteract combat stress during the Vietnam War. As a result, battlefield psychological breakdown occurred at a rate lower than in any previous war.[9] Despite these lower rates, many military personnel who did have stress reaction, and some who did not, developed symptoms after the war ended. Confusion still surrounded the nosology of responses to combat and other trauma. The aftermath of the Vietnam War provided an impetus for researchers to agree on how to describe the symptoms and classify the diagnoses. As a result, posttraumatic stress disorder (PTSD) was recognized as a long-term consequence of exposure to psychological trauma, whereas acute stress reaction was recognized as an immediate consequence of trauma.

Persian Gulf War

More recently, some Persian Gulf War veterans have developed PTSD. Gulf War syndrome has also emerged, characterized variably by fatigue, headache, muscle and joint pain, diarrhea, skin rash, shortness of breath, sleep disturbances, impaired concentration, irritability, and depression.[10] Controversy still surrounds the etiology of Gulf War syndrome. In some respects, the description is similar to the stress reactions in other wars, including the Da Costa syndrome and PTSD. But Gulf War syndrome could also be a physical reaction to an as yet unidentified toxin. More research is needed to clarify the nature and etiology of Gulf War syndrome.

PTSD Characteristics and Symptomatology

Mr. A displays some of the signs and symptoms of PTSD, which, as his case illustrates, can be a devastating syndrome. PTSD is one possible response to psychological trauma. Psychic trauma involves exposure to an event or events that carry the risk of death or severe injury to self or others, in conjunction with feelings of fear, helplessness, or horror in response to such an event. Experiences that can cause psychic trauma include military combat, rape, natural disaster, accidents, violent crime, and potentially maiming or life-threatening physical abuse. No evidence exists that PTSD develops from stress associated with divorce, harassment, or chronic illness.

By definition, PTSD is associated with marked social or occupational dysfunction. PTSD results in a great deal of human suffering and disability. Given its prevalence and resulting lost wages and decreased productivity, PTSD has a devastating economic impact nationally.

Three categories of symptoms characterize PTSD: reexperience of the trauma in a variety of ways, avoidance of stimuli associated with the trauma, and hyperarousal.

Patients whose symptoms include reexperiencing the trauma have intrusive recollections, nightmares, and flashbacks of the event, as well as psychological distress and reaction when exposed to cues that represent the original trauma. Patients who have symptoms of avoidance refrain from thoughts or feelings pertaining to the trauma, make efforts to avoid people and places or activities that are reminiscent of the trauma, have diminished interest in activities in general, feel detached from others, and have a sense of foreshortened future. Increased arousal symptoms include difficulty falling asleep or staying asleep, irritability, poor concentration, hypervigilance, and exaggerated startle. Symptoms from each of the three categories must be present for more than one month and must cause significant disturbances in social or occupational functioning for psychiatrists to diagnose PTSD.

After being exposed to trauma, most people have a reaction that is similar to PTSD. The symptoms, however, often abate after several days to weeks and constitute the acute stress reaction. A certain percentage of patients will continue to display symptoms for months or years after the initial trauma. PTSD can turn into a chronic state with little improvement over time. Indeed, some symptoms, notably nightmares, irritability, and startle, can worsen with age.

One form of PTSD has delayed onset. Combat veterans who have lived virtually symptom-free for many years after the original trauma may suddenly develop PTSD. Researchers do not completely understand this delayed response but suggest that life events such as

retirement, declining physical health, children moving out, or death of a parent or spouse may trigger the response.

Epidemiology of PTSD

Studies addressing the prevalence of PTSD have examined both community populations and subsets of people exposed to trauma. The lifetime prevalence of PTSD in the general population is between 1 percent and 9 percent.[11,12] Current PTSD prevalence in one study of Vietnam veterans was 15 percent for men and 9 percent for women; lifetime prevalence was 31 percent for men and 27 percent for women.[13] The reported rates of PTSD in women who have been raped vary from study to study. One study showed a 33 percent lifetime and 13 percent current prevalence of PTSD among these women.[14]

Etiology of PTSD

PTSD is one of the few psychiatric disorders defined by its cause. Without trauma, the disorder does not exist. Yet only a fraction of those exposed to trauma develop PTSD. What causes PTSD in the subset of people exposed to trauma? Three factors can predict the development of PTSD: 1) the predisposing elements present prior to the trauma, 2) the nature of the trauma, and 3) the aftermath of the trauma. The more extreme the trauma, the greater the chance of developing PTSD. The highest rates of PTSD among Vietnam veterans occurred in those who had the most intense combat experiences. Sixty-five percent of Auschwitz survivors developed PTSD, compared with 22 percent of Holocaust survivors who had not been in a concentration camp.[15]

Foy et al. analyzed combat veterans with and without PTSD for such variables as level of education, occupational status, family functioning, family history, length and severity of combat exposure, drug and alcohol abuse, and postmilitary assessment.[16] The variable that most affected PTSD expression was severity of combat exposure.

Researchers have also examined Vietnam veterans with and without PTSD to see if family psychopathology affects the variability of PTSD expression.[17] Those veterans with PTSD who had low combat exposure had higher rates of familial psychopathology than veterans without PTSD. Veterans with PTSD who had high combat exposure had similar rates of familial psychopathology as those who did not have PTSD.

Premorbid factors may predispose veterans to PTSD, particularly those veterans exposed to a lower dose of combat. Lack of social support can increase vulnerability to PTSD and can exacerbate the clinical course after the trauma. Premorbid conditions that predict PTSD are female gender, neuroticism, early separation from parents, prior anxiety or depression, familial anxiety disorder, and familial antisocial personality disorder.

Comorbidity with PTSD

PTSD, significantly disabling by itself, is associated with significant comorbidity. One study reports that 28 percent of current PTSD patients also have generalized anxiety disorder, 29 percent depression, 12 percent phobias, and 10 percent alcohol abuse.[18] Davidson and Fairbanks report that about 30 percent of Vietnam veterans with PTSD also have depression.[19] Male veterans with PTSD are twice as likely as those without PTSD to have a substance use disorder, and female veterans with PTSD are five times as likely.[13] Panic disorder and personality disorders, particularly antisocial personality disorder, are also highly comorbid with PTSD. These comorbid conditions further compromise psychological functioning and can complicate treatment.

Treating PTSD

Treatment is most effective immediately after the trauma. Clinicians encourage patients to talk about their experiences, which stimulates emotional processing. Patients can then begin to integrate and accept the overwhelming emotions. Crisis intervention is not a difficult technique and may reduce patients' chances of developing chronic PTSD.

Treating chronic PTSD is more complex and often involves a combination of pharmacotherapy and psychotherapy. Chronic PTSD is accompanied by heightened sympathetic tone, changes in the hypothalamic pituitary axis, opioid system abnormalities, possible serotonin transmitter abnormalities, and sleep alteration. Ideally, medications counteract the physiologic consequences of PTSD. But medications often do not cure PTSD and are used with other therapeutic modalities. Medications can treat some of the symptoms and reduce distress so that psychotherapy can be more effective.

Psychotherapy, both individual and group, is a well-researched therapeutic modality for treating PTSD. A variety of individual therapies exist: cognitive/behavioral-based therapy, dynamic therapy, supportive therapy, or a combination of these approaches. Each therapy relies on building a positive relationship—called a therapeutic alliance—that engenders a sense of trust and safety.

Group therapy emerged as a major therapeutic modality for Vietnam veterans with PTSD. Group therapy gives individuals a sense of understanding and community that only those similarly traumatized can offer. Group therapy counters isolation and social withdrawal and helps patients process intense affects that group settings can generate. Family therapy can be a primary therapy or an important adjunct to other therapies. With a host of different approaches, informed therapists can tailor treatment to patients' needs.

Conclusion

PTSD is a complex syndrome that consists of maladaptive responses to a traumatic event. A good deal of what researchers know about PTSD comes from studying combat veterans. Yet many questions regarding chronic PTSD remain unanswered. Researchers need to better characterize risk factors and premorbid conditions leading to PTSD and to develop pharmacologic and psychotherapeutic treatment modalities that are more efficacious in chronic PTSD. Researchers also need to further

develop treatments for comorbid conditions, particularly substance use disorders. Further research on combat veterans and civilians will provide the medical community techniques to better treat Mr. A and patients similar to him. MM

Michael Dieperink is a staff psychiatrist in the Department of Psychiatry at the Veterans Affairs Medical Center in Minneapolis.

REFERENCES

1. Da Costa JM. On irritable heart: a clinical study of a form of cardiac disorder and its consequences. Am J Med Sci 1871;61:17-52.
2. Hyams KC, Wignall FS, Roswell R. War syndromes and their evaluation: from the U.S. Civil War to the Persian Gulf War. Ann Intern Med 1996;125(5):398-405.
3. Kentsmith DK. Principles of battlefield psychiatry. Milit Med 1986;151:89-96.
4. Grinker RR, Spiegel JP. Men under stress. Philadelphia: Blakiston, 1945.
5. Archibald HC, Long DM, Miller C, Tuddenham RD. Gross stress reaction in combat: a 15 year follow-up. Am J Psychiatry 1962;119:317-22.
6. Wolf S, Ripley H. Reactions among allied prisoners of war subjected to three years of imprisonment and torture by the Japanese. Am J Psychiatry 1947;104:180-92.
7. Noble D, Roudebush M, Prince D. Studies of Korean War casualties part I: psychiatric manifestations in wounded men. Am J Psychiatry 1952;108:495-9.
8. Sutker PB, Winstead DK, Galina ZH, Allain AN. Cognitive deficits and psychopathology among former prisoners of war and combat veterans of the Korean conflict. Am J Psychiatry 1991; 148:67-72.
9. Bourne PG. Men, stress and Vietnam. Boston: Little, Brown, 1970.
10. Milner IB, Axelrod BN, Pasquantonio J, Sillanpoa M. Is there a Gulf War syndrome? [Letter]. JAMA 1994;271:661.
11. Helzer JE, Robins LN, McEvoy L. Post traumatic stress disorder in the general population. NEJM 1987;317:1630-4.
12. Davidson JRT. Posttraumatic stress disorder and acute stress disorder. In: Kaplan HI, Sadock BJ, eds. Comprehensive textbook of psychiatry. 6th ed. Vol I. Baltimore: Williams and Wilkins, 1995:1227-36.
13. Kulka RA, Schlenger WE, Fairbank JA, et. al. Trauma and the Vietnam generation: report of findings from the national Vietnam veterans readjustment study. New York: Brunner/Mazel, 1990.
14. Kilpatrick DG, Saunders BE, Veronen LJ, Best CL, Von JM. Criminal victimization: lifetime prevalence, reporting to police, and psychological impact. Crime Delinq 1987;33:479-88.
15. Kuch K, Cox BJ. Symptoms of PTSD in 124 survivors of the Holocaust. Am J Psychiatry 1992;149:337-40.
16. Foy DW, Sipprelle RC, Rueger DB, Carroll EM. Etiology of posttraumatic stress disorder in Vietnam veterans: analysis of premilitary, military, and combat exposure influence. J Consult Clin Psychol 1984;52:79-87.
17. Foy DW, Resnick HS, Sipprelle RC, Carroll EM. Premilitary, military, and postmilitary factors in the development of combat-related posttraumatic stress disorder. Behavior Therapist 1987;10(1):3-9.
18. Shore JH, Vollner WM, Tatum EL. Community patterns of post-traumatic stress disorder. J Nerv Ment Dis 1989;177:681-5.
19. Davidson J, Fairbanks JA. The epidemiology of posttraumatic stress disorder. In: Foa D, ed. Posttraumatic stress disorder: DSM-IV and beyond. Washington, D.C.: American Psychiatric Press, 1993.

Family Practice Variety

HealthPartners has a variety of opportunities for BC/BE family practitioners. These are primarily adult practices, some full range and some limited range, most in ambulatory settings. Urban or suburban practices are available.

HealthPartners Bloomington Clinic
Large suburban clinic located in Bloomington, just south of Minneapolis.

HealthPartners Riverside Clinic
Just outside of downtown Minneapolis, this clinic serves a widely diverse population.

HealthPartners Skyway Clinic
Downtown Minneapolis clinic practice involving no OB and limited peds.

HealthPartners Woodbury Clinic
Our newest clinic, located in the fastest growing suburb of St. Paul. Full range practice.

Ramsey Clinic Maplewood
Suburban location with a full range practice including peds with OB optional.

For more details on specific openings and clinic sites, contact Lori Fake at (612) 883-5337 or (800) 472-4695. For consideration, forward your CV to: HealthPartners, Physicians Services, P. O. Box 1309, Minneapolis, MN 55440-1309. EO/AA Employer.

HealthPartners

HealthPartners' mission is to improve the health of our members and our community

EARN WHILE AN INTERN



WE GIVE YOU MORE PLACES TO GO WITH YOUR CAREER

The Navy is accepting applications for: Orthopedic, Family Practice, OB/GYN, Undersea Medicine, General Surgery, Anesthesiology, Flight Surgeon and others.

Location and Benefits:

- Excellent Salary And Benefits Packages
- Challenging Assignments
- Relocation Expenses Paid
- Professional Development
- Worldwide Location

FOR MORE INFORMATION CALL: 1-800-247-0507 (MN)
1-800-558-0068 (WI)

NAVY PHYSICIAN You and the Navy. Full Speed Ahead.

The Monitor
News For Minnesota Physicians

New Spirit of Bipartisanship Flourishes at Capitol

The 1997 session of the Minnesota Legislature began in a new spirit of bipartisanship. "Leaders in both parties believe the voters spoke loudly, demanding that the partisan bickering be put aside and that legislators work together to solve the problems before the state," said David Renner, MMA director of policy and legislation. "It has been refreshing to see this cooperation. The cynics are expecting it to last only until the first politically hot issue arises."

Welfare reform is expected to dominate the House and Senate health care committees as they consider legislation to bring Minnesota into compliance with the new federal reforms. A welfare bill was one of the first to be introduced. Sen. John Hottinger, DFL-Mankato, chair of the Senate Health and Family Security Committee, and Rep. John Dorn, DFL-Mankato, chair of the House Health and Human Services Committee will be key players in discussions of the welfare bill and all other health care proposals. Hottinger is an attorney who has served in the Senate since 1990. Dorn is a high school English teacher who has been in the House since 1986. The MMA will be monitoring welfare proposals to make sure that access to health care is not reduced.

Bill Aims To Keep Kids from Buying Tobacco

Once again the Minnesota Medical Association, working through the Smoke-Free 2000 Coalition, is squaring off against the tobacco industry at the Minnesota Legislature. In the first few days of the 1997 session, Sen. Ember Reichgott Junge, DFL-Minneapolis, introduced the Smoke-Free Coalition's bill, S.F. 6, to restrict children's access to tobacco. Rep. Ann Rest, DFL-New Hope, introduced the House companion bill, H.F. 117. This proposed legislation would require local units of government to license the retail sale of tobacco, set penalties against license holders for sales to minors, and require regular compliance checks.

Last year a similar bill was torpedoed by a tobacco industry amendment, which would have preempted stronger laws passed by local communities. The amendment was stripped from the bill on the House floor and the bill's author, Rep. Loren Jennings, DFL-Harris, who is sympathetic to the tobacco industry, pulled the bill from consideration. The tobacco industry's failure to pass a preemption amendment was a victory for anti-smoking advocates. The MMA and the Smoke-Free Coalition will continue to support higher state penalties for selling tobacco to minors while at the same time trying to preserve the right of local communities to pass stronger measures to protect children from tobacco addiction.

The tobacco industry's fight for preemption may move to the national level. According to Sen. Paul Wellstone's staff, tobacco companies may seek federal legislation to preempt the ability of local communities to enact strong measures to

Capitol continued on page 35

Announcements

MMA Offers Conference on CPT, RBRVS, and Correct Coding Updates

The Minnesota Medical Association's annual conference, "1997 CPT, RBRVS, and Correct Coding Updates," will be held in St. Paul and Duluth in February. These half-day sessions are designed to inform participants about the major changes to the coding system used to report physicians' services to third-party payers. The sessions will also include an overview of the five-year update to the RBRVS fee schedule, and an overview of the Medicare coding changes for 1997.

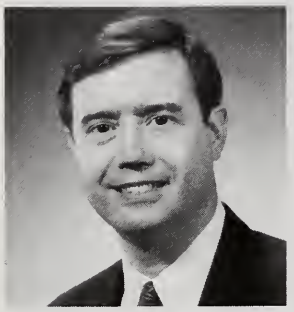
St. Paul
February 11
Sheraton Inn Midway
Session I–8:30 a.m. to 12:30 p.m.
Session II–1 p.m. to 5 p.m.

Duluth
February 20
Holiday Inn
9 a.m. to 1 p.m.

The coding seminar was held February 4 in Mankato and February 6 in St. Cloud.

Visit the MMA Home Page

The MMA Web site includes information on MMA legislation and advocacy, news, a staff directory, links to related organizations, discussion groups, CME information, and links to the best clinical resources and products and services. Visit the MMA home page at: www.mnmed.org



Viewpoint

Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

Do We Have Enough Quality Yet?

How can we make sure that the quality of health care is not sacrificed to the bottom line? How do we measure quality? These questions have been debated ever since economic pressures began to squeeze the Minnesota health care system.

Concerns about quality have spawned numerous efforts to measure physician performance. Recently, I made a list of the ways I am evaluated as an emergency physician.

1. The Minnesota Board of Medical Practice annually reviews my continuing education, my health, whether I use drugs and alcohol, whether I have a criminal record, and whether any malpractice complaints were brought against me.

2. Every two years, the hospital inspects my credentials and checks on the number of procedures I have performed to see if I can continue with my privileges.

3. My fellow emergency department physicians review a sampling of my charts the day after I see patients.

4. The radiologists review my x-ray readings for any missed findings.

5. The hospital utilization review department checks on the appropriateness of my admissions.

6. The insurance companies and HMOs review my admissions, lab, x-ray, and pharmacy utilization.

7. The federal government (Health Care Financing Administration) reviews my Medicare admissions.

8. The director of the emergency department annually reviews my performance.

9. The federal government reviews my medical record documentation and billing information.

10. The Joint Commission on Accreditation of Health Care Organizations reviews my charts to see that orders for restraints are properly written and that patients requiring sedation are being monitored.

11. The customer service program reviews any complaints patients might have about me. Phone and mail surveys are conducted to ask the patients if they are satisfied with the care I provided and if the treatment made them better.

12. My malpractice insurer and attorneys review any bad outcomes that may occur.

13. The Minnesota Department of Health and the Minnesota Department of Human Services review some services.

14. Somehow I suspect there are others out there I'm not even aware of who are doing quality assurance.

Has there been a cost/benefit analysis of all these quality assessment efforts? Perhaps some of the money spent on quality assurance could be better spent on direct patient care.

Quality assurance is important. Instead of many overlapping efforts, however, we should have a few good quality assurance measures that are accurate, unbiased, and reproducible.

The Minnesota Health Data Institute may be the most appropriate organization to collect scientific data on health care quality. The institute is a public-private partnership between the Minnesota commissioner of health and a 20-member board of directors that includes representatives of the state, the insurance industry, health care purchasers, and providers. Its goal is to provide information on cost and quality of health care services. A patient satisfaction survey, health plan report card, and outcomes studies are conducted under its auspices.

Support for the data institute has begun to erode, partly because of lack of agreement on how to fund it. In 1995, the institute released a long, complex report on consumer satisfaction with health plans that was expensive to produce and not very helpful to consumers trying to choose a health plan. Critics questioned whether the data institute should continue. The MMA formed an ad hoc task force to discuss the issue.

Recently, this task force recommended that the MMA "continue to support the concept and existence of the Minnesota Health Data Institute." The data institute offers a public forum where MMA physicians can participate in developing data collection standards and determining protocols. Four MMA members serve on the institute's board of directors.

If the data institute were disbanded, health plans might conduct their own data initiatives, geared to marketing, and their data would probably not be comparable to data of other plans. In addition, the Legislature might ask the Minnesota Department of Health to collect health plan and clinic-specific data. My list would grow a little longer. It's important to pare down the number of quality assurance efforts and focus on curing our patients.

What I would really like is fewer reviewers and a little more help in the emergency department taking care of all these sick people.

Talking Points: Why Replace the 2 Percent Health Care Tax?

There Is a Surplus in the Health Care Access Fund

There is currently a $419 million surplus in the Health Care Access Fund. It is expected to grow to $589 million by the year 2001. Clearly, the 2 percent health care tax raises more money than is needed to fund the MinnesotaCare program. The tax should be reduced to 1 percent in July 1997 as a first step toward replacing it with a more appropriate tax by 1999.

MMA Supports Commitment to Uninsured

The Minnesota Medical Association strongly supports the MinnesotaCare program for the uninsured and has fought to expand its eligibility. The governor has refused to sign bills increasing MinnesotaCare eligibility.

Surplus Shouldn't Be Used for Anything but MinnesotaCare

The Health Care Access Fund was created to fund the MinnesotaCare program. It should not be used for any other purpose—no matter how worthy that purpose may be.

MinnesotaCare Funding Should be Broad-based

Providing access to affordable health care for the uninsured is a commitment by **all** Minnesota citizens.

Like society's commitment to provide education for children, or good roads, or libraries, the commitment to the uninsured should be supported by a broad-based tax such as an income tax.

Higher cigarette taxes and alcohol taxes would also be appropriate because they would encourage healthy choices and would help pay the cost of treating tobacco- or alcohol-related illness or injury.

Funding Should Provide Long-range Stability

A stable, broad-based tax will ensure the long-range stability of the MinnesotaCare program and will reflect the fact that helping to provide health care for the uninsured is the responsibility of the entire Minnesota community.

Funding Should Be Fair

It is not fair to place the tax burden for the MinnesotaCare program on one segment of the population. Teachers don't pay a special tax to fund education; construction workers don't pay a special tax to fund roads; librarians don't pay a special tax to put books on the library shelves. Providers should not pay a special tax to fund health care.

Pass-through Doesn't Work

Lawmakers who drafted the MinnesotaCare legislation intended the tax to be passed through to health plans, but providers find little evidence that this is happening. Large plans bury the tax in their overall payment to providers so it is impossible to tell whether or not they pay the tax. If — as the plans claim — the tax is being passed through, then the tax is raising the overall cost of health care.

Trying to collect the tax is an administrative nightmare for small clinics. The extra paperwork adds to the clinic's administrative expenses.

It costs the state money to enforce payment of the 2 percent tax.

Tax Hurts Rural Minnesota

In rural Minnesota, the 2 percent health care tax threatens the financial survival of some small clinics. Rural clinics treat a large population of Medicare, Medicaid, and MinnesotaCare patients, who pay fees that are limited by the state and are lower than regular fees. When the 2 percent tax is added to the limited reimbursement rates for public programs, rural physicians find it hard to cover the cost of providing care.

Capitol *continued from page 33*

prevent children from buying cigarettes and other tobacco products.

The MMA will also support higher tobacco taxes to encourage smokers to quit and to deter people, especially teenagers, from starting to smoke. Research shows that teenagers are three times more likely than adults to quit smoking, or not to start, in response to a cigarette tax increase. It is projected that for every 10 percent increase in cigarette prices, demand among children and teenagers declines by as much as 14 percent.

Support for 2 Percent Tax Reduction Grows

Minnesota Medical Association efforts to begin phasing out the 2 percent health care tax met with support from legislators and other providers. The MMA proposes that the state begin using a portion of the projected $419 million surplus in the Health Care Access Fund to reduce the 2 percent tax to 1 percent this year. The second phase of the reduction would be slated for July 1999 during the next biennium.

At a Medical Alley breakfast meeting January 8, an informal survey of about 30 to 35 legislators and 40 to 50 Medical Alley members found support for the Minnesota Medical Association position on reducing the 2 percent health care tax. When asked how the current surplus in the Health Care Access Fund should be used—choosing among options such as funding medical ed-

Capitol continued on page 37

LEGAL NEWS

Supreme Court Won't Hear Surcharge Appeal

The U.S. Supreme Court has denied the Minnesota Medical Association's request and refused to hear an appeal of the medical license surcharge decision. The MMA had asked the U.S. Supreme Court to consider the Minnesota Supreme Court's dismissal of the appeal of a lawsuit charging that Minnesota's retroactive application of the $400 surcharge on physicians' medical licenses was unconstitutional. The class action sought refunds of the $400 surcharge on medical licenses issued or renewed from April 1 to September 30, 1992. The physicians argued that it was illegal for the state to require them to pay the surcharge because the tax law did not take effect until October 1, 1992. They charged that the retrospective application of the tax violated their constitutional guarantees of due process and equal protection. The MMA has been actively involved in this case from the beginning.

Advisory Opinion Clarifies Changes to Medical Records Law

The Minnesota Department of Administration issued an advisory opinion, which may help clarify the amendments to the statute governing the release of medical records that took effect January 1. Under the new law, providers must inform their patients in writing that their medical records may be released for research purposes, and patients have the right to object to the release. In addition, providers must obtain the patient's written general authorization for release of the records for research purposes and must note in the medical record when the medical record is released without the patient's consent for any purpose authorized by law.

The commissioner of administration's advisory opinion defines the health record for this purpose as being "complete and current information possessed by that provider concerning any diagnosis, treatment, and prognosis of the patient." Furthermore, the opinion clarifies that the release provisions are triggered only when a data subject's provider is asked to release a subject's health record to an entity external to the provider.

The advisory opinion, which is available as a public document, will be a useful resource for providers and their legal advisors to use in interpreting the changes to the Medical Records Act and applying them in practice. Although the commissioner's advisory opinion is directed to public institutions, it provides useful insights into an appropriate and good faith interpretation of the changes to the Medical Records Act. The advisory opinion was issued December 5, 1996, in response to a request from a public hospital.

For more information, call Patricia Franklin, J.D., MMA director of legal affairs, at 612/378-1875 or 800/999-1875.

ANNOUNCEMENTS

Rural Health Committee Recommends Legislation

The Office of Rural Health Advisory Committee has submitted its report to the 1997 Legislature, "Rural Health Care Access and the Need for an Alternative Licensure Model for Rural Hospitals." The report recommends that Minnesota seek federal legislation that would establish an alternative license for rural hospitals to ease regulatory burdens and improve Medicare reimbursement. The report also suggests ways to improve rural emergency services and recommends setting up a demonstration project for a rural community health center.

Sen. Craig Thomas, R-Wyoming, is working with the National Rural Health Association to draft a comprehensive federal rural health bill. Sen. Rod Grams, R-Minn., is drafting a rural emergency medical services bill, which he plans to introduce in February.

MMA Will Sponsor Youth Summit

The Minnesota Medical Association will once again join the office of Attorney General Hubert H. Humphrey and the University of Minnesota's Center for Community Legal Education at the Center for 4-H Youth Development in sponsoring a Youth Summit in St. Paul. High school students throughout the state will have an opportunity to come to the Capitol and learn about the legislative process on February 11.

The topic of this year's youth summit is hate crimes. Last year, the summit topic was the MMA's proposal to strengthen the negligence statute governing gun storage. The topic stirred lively discussions and was the subject of many news articles. The MMA did succeed in changing the law against negligently storing or leaving a loaded firearm where a child is likely to gain access to it so that the law now applies to young people under age 18. It previously applied to children under age 14.

Capitol *continued from page 35*

ucation, funding the Minnesota Comprehensive Health Association, or expanding MinnesotaCare eligibility—69 percent said they would like to reduce the tax. Fifty-two percent said they would favor using the General Fund to finance the MinnesotaCare program rather than the dedicated Health Care Access Fund.

The MMA is building an informal coalition of other providers who pay the tax, including dentists, chiropractors, podiatrists, psychologists, pharmacists, drug wholesalers, physical therapists, and occupational therapists to help convince legislators.

"While MMA efforts are going well, this is still an uphill battle," said David Renner, MMA director of policy and legislation. "The Legislature very rarely reduces a tax that is in place unless there is an outcry to do so." He encouraged MMA physicians to write or call their legislators and encourage them to support use of the Health Care Access Fund surplus to reduce the 2 percent tax. For arguments in support of replacing the 2 percent tax, see page 35.

• • • • •

Talk Back

• What is your clinic's experience with the 2 percent tax?

• How does the tax affect you and your patients?

• Does the pass-through work? Why or why not?

• How much does it cost your clinic to do the paperwork related to the tax?

The MMA wants to hear about your personal experiences—specific anecdotes that illustrate MMA arguments in favor of repealing the tax. Call Lorrie Holmgren at 612/378-1875 or 800/999-1875, or E-mail to lholmgren@mnmed.org

CAGE Questionnaire

Physicians can play an important role in preventing alcohol-related diseases through health counseling. Alcohol, the most widely used drug in Minnesota, led to 4 percent of all deaths in the state in 1995. Thirty-one percent of these deaths were caused by unintentional injury and 30 percent were caused by violence.

CAGE Resolution

To help physicians identify patients who may be abusing alcohol, the 1996 MMA House of Delegates adopted a resolution calling on the MMA to educate Minnesota physicians about the CAGE questionnaire. Speaking in favor of the resolution, Sally Trippel, M.D., Rochester, urged all physicians to use the CAGE to screen for alcohol problems. "It takes two or three minutes and costs nothing. That's a pretty cheap way to pick up a disease that has many costly ramifications for the individuals and their families," Trippel said.

CAGE Questions

The CAGE questionnaire includes four simple questions:

1. Have you ever felt you ought to cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?

Where Do You Draw the Line?

How many "yes" answers signal alcoholism? "Two or three affirmative answers should create a high index of suspicion. Four positive responses is seen as pathognomonic for alcoholism," according to a 1982 article in *Alcohol Clinical Update*. The paper that introduced the CAGE questionnaire in 1970 stated that a medical diagnosis of alcoholism should not be based solely on affirmative answers to the questions, but that even one positive reply should raise suspicion and prompt further inquiry.

CAGE has been shown to be more accurate in identifying alcoholics than laboratory tests using gamma-glutamyl transpeptidase. It is also easy to administer and less intimidating than some other methods.

CAGE is a mnemonic acronym for:
Cutting down?
Annoyed by criticism?
Guilty feeling?
Eye openers?

The CAGE questions were developed from a clinical study at North Carolina Memorial Hospital in 1968. The results were presented in a paper by J.S. Ewing and B.A. Rouse at the International Conference on Alcoholism in Australia in 1970. For more information on how the questions were identified and their use in clinical and research studies, see "Detecting Alcoholism" by John A. Ewing, M.D., in the October 12, 1984, *Journal of the American Medical Association (JAMA)*.

Other Screening Methods

The article, "Screening for Problem Drinking in Older Primary Care Patients," in the December 25 *JAMA*, recommends asking questions on the quantity and frequency of drinking in addition to administering the CAGE. The authors are W.L. Adams, M.D.; K.L. Barry, Ph.D.; and M.F. Fleming, M.D., M.P.H.

• • • • •

Keep Track of Health Care Bills

For information about health care legislation, call House Information at 612/296-2146 or 800/657-3550, or Senate Information at 612/296-0504 or 888/234-1112. Locate information on-line at www.leg.state.mn.us. • • • • •

Announcements

There is a Vacancy on the Medicaid Drug Formulary Committee

There is an opening for a physician on the Minnesota Medicaid Drug Formulary Committee. The purpose of the nine-member committee is to advise the Minnesota Department of Human Services on drug coverage for the Medical Assistance Program. Applicants may not be employed by the Department of Human Services and their practice must be primarily with persons paying privately or through health insurance. Members currently serve three-year terms and volunteer their time and service to the committee. The department will reimburse members for mileage expenses to and from committee meetings and will award continuing education credits for attending committee meetings. For more information, call Pat Hanson at 612/362-3738, or 800/999-1875.

Managed Care Expands

The Minnesota Department of Human Services is planning to extend managed care for Medical Assistance and General Assistance Medical Care into nine additional counties: Becker, Clay, Faribault, Isanti, Kandiyohi, Mahnomen, Martin, Norman, and Swift. Enrollment will begin in some of the counties as early as June 1997.

Seat Belts Are Key to Air Bag Safety

Fears about air bag injuries may spur efforts to strengthen Minnesota's seat belt law. "Air bags are supplements to seat belts. They were never designed to be used alone," Don McNamera, director of the National Highway Traffic Safety Administration (NHTSA) Region V told members of the Minnesota Passenger Protection Coalition, which includes the Minnesota Medical Association. A law that would allow police officers to stop and ticket motorists who are not wearing a seat belt "will save more lives than anything else you can do in public safety," McNamera said. Seat belt use goes up 15 percent when such a law takes effect. Drivers without seat belts risk injury or death if their air bag deploys.

Currently, Minnesota law requires automobile occupants to wear seat belts, but violators can only be ticketed if they have been stopped for another offense. The MMA supports stronger seat belt laws.

Since 1986, when air bags were first installed in U.S. cars, air bags have been deployed 800,000 times, saving the lives of 1,500 drivers and 175 passengers. Nineteen drivers and 35 passengers, however, have been killed by misuse of air bags. The majority of drivers were not wearing a seat belt. Most of the passengers were infants or small children riding in the front seat. None of the fatalities occurred in Minnesota.

Air bags inflate at speeds up to 200 m.p.h. to protect adults in front-end collisions. Air bags can kill people who are too close to them. Seat belts restrain and protect drivers and passengers. The head of an infant in a rear- facing seat is directly in front of the air bag as it inflates with tremendous force.

Currently, it is illegal to disconnect an air bag. It is possible, however, to petition NHTSA for permission to disconnect an air bag for a medical reason such as a tracheotomy tube.

Because of public fears, NHTSA has asked for comments on a proposed rule that would allow any vehicle owner to have the air bag disconnected by a dealer or repair shop. NHTSA will also ask for comments on two alternatives that would allow air bags to be depowered by 20 percent to 35 percent. McNamera pointed out there would be a tradeoff. Less powerful deployment will mean less protection as well as less danger from misuse. In the future, NHTSA will issue a proposal calling on the automobile industry to develop "smart" air bags that will be able to sense the size of individuals and adjust the force at which they deploy.

Air Bag Safety Tips

- Everyone in the car should wear a seat belt at all times.
- Babies in rear-facing infant seats should **never** ride in the front seat of a car with a passenger-side air bag.
- Children age 12 and under should ride buckled up in the **back seat.**
- Children age 8 and under should ride in booster seats in the back seat.
- Driver and front passenger seats should be moved as far back as possible. There should be at least 10 to 12 inches between the air bag and the driver or passenger.
- Pregnant women should position the shoulder strap of the seat belt over the collarbone and place the lap belt under the abdomen as low as possible on the hips and across the upper thighs, never above the abdomen.

Schools May Heed Doctors' Advice on School Start Times

Three years ago, the Minnesota Medical Association wrote to all state school superintendents and urged them to eliminate early school start times for teenagers. Now MMA efforts are beginning to achieve results.

MMA Campaign

Responding to a resolution adopted by the 1993 MMA House of Delegates, the MMA told schools and the public that adolescents need more than nine and one half hours of sleep, more sleep than younger children or adults. In addition, there is scientific evidence that the timing of the adolescent sleep period is geared to later hours — teenagers are not able to fall asleep as early as younger children and they tend to sleep later. The MMA warned that sleep deprivation causes accidents and interferes with learning.

In Minneapolis, all seven public high schools and most middle schools still start at 7:15 a.m. and end at around 2 p.m. Elementary schools start at 9:40 a.m. and end at 3:55 p.m. This schedule is the exact reverse of one that would be based upon the sleep patterns of adolescents and children.

Schools Consider Change

But school schedules may change soon. Educators and the public heard the MMA's message and they have been studying ways to juggle bus schedules and sports practice in light of the new information.

Minneapolis set up a Start Time Task Force, which is studying ways to readjust the schedules of elementary, middle, and high schools. "Since the MMA introduced the idea, it has become conventional wisdom that school times should be changed," said Denny Shapiro, who has been active in leading parent efforts for change. "High school start times have been lumped with other issues. In a school district as large as Minneapolis, if you change one thing, there is a ripple effect all through the system." Transportation expense, the danger of younger children waiting for buses in the dark, and conflict with after-school jobs and sports are some of the barriers to change. The St. Paul school district is also considering change.

Gov. Arne Carlson, in his state of the state address, said that it was important to consider "what's best for the kids" in making decisions about school start times.

Suburbs Take Lead

In the suburbs, Edina led the way by changing its start time from 7:25 a.m. to 8:30 a.m. for the 1996-97 school year. Other schools are considering a change for the fall of 1997. Seventeen suburban school districts, including Hopkins, Burnsville, Lakeville, and Mounds View, are working with the Center for Allied Research and Education Improvement at the University of Minnesota to study school start times, sleep deprivation, and learning. The schools were especially interested in the reaction to Edina's later school start time. Kyla Wahlstrom, the primary researcher, said that Edina's experience should be reassuring to other schools that are considering change. "After much worry before making the change, Edina parents and students are loving it," said Wahlstrom. The study includes surveys of 7,000 students and 3,000 teachers, as well as information from coaches, parents, and police officers. The results of the study are expected soon. Watch the *Monitor* for more information.

The issue of adolescent sleep needs and its relation to school start times has stirred interest throughout the country. The MMA receives daily phone calls and requests for information from parents and educators throughout the nation. • • • • •



Raymond G. Christensen, M.D., MMA president, accepted the AMA President's Citation for Service to the Public from Daniel H. "Stormy" Johnson, M.D., AMA president, at the AMA Interim Meeting in December. The award recognizes the MMA Stop the Media Violence Campaign.

ANNOUNCEMENTS

Wellstone Proposes AMA Patient Protections

"The bottom line can't be the only line," said Sen. Paul Wellstone, DFL-Minnesota, at a town meeting in Duluth to discuss proposed federal legislation that would define the rights of health care consumers and providers. The purpose of the meeting was to gain input from Minnesotans before completing a draft of a revised patient protection bill to be introduced this session. The legislation is expected to be similar to the patient protection bill that Wellstone helped the American Medical Association draft last year.

The bill will require disclosure of information about health plans, guarantees of patient access to specialty care, and an appeals process when new therapies are denied. Wellstone called this legislation "sensible consumer protection."

John Van Etta, M.D., chair of the MMA committee on legislation, raised the problem of the wide variations in Medicare reimbursement based on location, which shortchange Minnesota seniors and physicians. "The number one health care priority is Medicare equity," Wellstone responded.

• • • • • • •

Congress Focuses on Health Insurance for Children

Health insurance for children is a hot topic in Washington, D.C. Both parties are working on proposals to provide insurance for children in poor families.

• Providing coverage for 10 million uninsured children is expected to be one of the main themes in President Clinton's budget plan. He proposes to enroll 3 million uninsured children in Medicaid who are eligible but not participating and to phase in an additional one million uninsured children, ages 13 to 19, over the next four years. The administration is looking at several proposals to provide coverage for uninsured children who are not eligible for Medicaid.

• Sen. Majority Leader Trent Lott, R-Miss., said Republicans will also present a proposal for uninsured children. The GOP are talking about tax incentives or giving states federal funds to cover more children through Medicaid.

• Massachusetts Sens. Edward M. Kennedy and John Kerry, both Democrats, have proposed a bill that would give block grants to help states buy health insurance for pregnant women and children in families with incomes up to three times the federal poverty level ($31,080 for a family of two and $38,940 for a family of three).

• Rep. Fortney Stark, D-Calif., has proposed a bill that would provide a refundable tax credit to help low-income families buy private insurance for their children.

• Sen. Minority Leader Thomas Daschele, D-S. Dak., is developing a plan to provide tax credits and tax deductions to pay for insurance coverage for children in families with incomes up to three times the federal poverty level.

• • • • • • •

MMA Calls for Medicare Reform

The MMA joined 33 other state societies in signing a unity letter drafted by the AMA. The letter calls on Congress and the Clinton administration to develop and pass Medicare legislation that would achieve these four goals:

• Assure Medicare's fiscal solvency while preserving high levels of access for Medicare patients.

• Preserve patients' rights to choose their own physician while modernizing the traditional Medicare program.

• Expand patient choice of Medicare plans and coverage options.

• Set the stage for longer term policy changes to cope with the increased demands that will be created by the aging of the baby boom generation.

The letter noted that, in the past, physicians have absorbed a disproportionate share of Medicare's provider cuts.

• • • • • • •

Medicaid Spending Slows

Medicaid spending growth dropped from 22.4 percent between 1988 and 1992 to 9.5 percent between 1992 and 1995, according to a survey by the Kaiser Family Foundation. Medicaid growth is expected to average 7.4 percent per year through 2002. The American Medical Association says that spending slowdowns were caused by limitations on disproportionate share spending, slower enrollment growth, and slower growth in spending per beneficiary.

The Monitor
FEBRUARY 1997
• • •
President
Raymond G. Christensen, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Director, Communications
Mark S. Vukelich

Editor
Lorrie Holmgren
• • •

Special Early Factory Order Pricing on New 1997 Sport Utility Vehicles Through MMBR Motor Services

member, whether you purchase or lease, MMBR Motor Services d Creative Leasing, Inc. will help you get the most vehicle the best price. We'll even help you sell your old auto.

e your money wisely. For personal attention and lease or rchase information on any vehicle, call 612/623-2860, or toll-e 800/298-MMBR.

MBR Motor Services is a service of Minnesota Medical Business sources, a physician-owned corporation of your medical association.

w Vehicle Leases**

ke/Model	MSRP	Your Price*	24 Mo	36 Mo	48 Mo	60 Mo
GMC Jimmy SLS 4dr	$27,072	**$24,904**	$433	$371	$345	$326
Chevrolet Blazer LS 4dr	$27,482	**$25,251**	$399	$345	$316	$329
Ford Explorer XLT 4dr	$28,880	**$26,025**	$385	$347	$325	$334
Jeep Grand Cherokee Laredo	$28,188	**$26,149**	$455	$380	$351	$332
Nissan Pathfinder SE	$30,618	**$28,568**	$496	$407	$372	$354
GMC Yukon SLE 4dr	$32,999	**$31,327**	$477	$422	$391	$375
Chevrolet Tahoe LS 4dr	$32,935	**$31,270**	$476	$421	$391	$375
Chevrolet Suburban 1/2 LS	$36,457	**$34,293**	$537	$483	$444	$423
Toyota 4-Runner SR5 4dr	$31,953	**$30,549**	$507	$429	$382	$349
Mitsubishi Montero LS 4dr	$31,690	**$30,361**	$546	$476	$446	$409
Ford Expedition XLT 4dr	$33,645	**$31,259**	$421	$398	$387	$369

ale price before tax, license, license fees, and 1997 price increase.
ll lease payments listed above are monthly lease payments before tax on factory ordered leases. These lease payments are based on a 0.00 cap reduction and 15,000 miles/year. The only moneys needed to start the above leases are first payment, security deposit, and cense for the first year.



MMBR

MOTOR SERVICES

MINNESOTA MEDICAL BUSINESS RESOURCES OWNED BY MMA & HMS

The average 50-year-old leaves the work force at 63, and has put away just $57,056 for a retirement that will probably last over 20 years.

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED

How can you bridge the gap to afford a long, active retirement?

And then, there's college to think about for your children — In the year 2015, four years at a state university are expected to cost $42,530 — at a private college, $184,884. How will you bridge the gap to afford a college education for your children?

Because retirement and college education funding are such a concern, your association, through MMBR, has invested in the best technology and people to help you bridge the gap to your financial success. We offer educational seminars, personal financial/estate reviews and high quality products that can make the difference.

So, if you need help with your financial blueprint, talk with us. We will listen. We have the tools to help. Together we can bridge the gap to your successful financial future.



To find out more, call MMBR and ask for Barry Weber.

800-298-6627

MMBR

Minnesota Medical Business Resources
Owned By MMA & HMS

Caring for Persons with AIDS in Greater Minnesota

Heather Chial, B.A., and Barbara A. Elliott, Ph.D.

ABSTRACT

This study identifies ways in which physicians in rural and nonurbon settings can better meet the needs of caregivers for persons with HIV/AIDS. We interviewed 14 caregivers living in these settings and documented their experiences and needs. Caregivers indicated that physicians had been providing needed medical care, instructions on how to care for persons with AIDS, and information about the disease. However, caregivers also described a continuing need to be included in the decision-making care team, to have better access to social services, and to have additional personal support. Physicians, especially those in rural and nonurbon areas, need to be informed about and able to access community services that will help meet caregivers' needs. We also describe a support group for caregivers developed to address some of these needs.

Physicians treat most persons with AIDS on an outpatient basis. Therefore, the majority of care takes place in the home. Informal caregivers—parents, siblings, spouses, partners, friends, and volunteers—play an important role in providing care for persons with HIV/AIDS. These caregivers make it possible for persons with AIDS to remain in the community, especially in the later stages of the disease.[1]

To better meet the needs of patients with HIV/AIDS and their caregivers, physicians need to understand what informal caregiving involves. Unfortunately, research in the field of family caregiving for persons with AIDS is quite limited.[1,2] In particular, little research has addressed the needs of caregivers in rural and nonurban settings.

Physicians can play a key role in facilitating access to health care and social services available for persons with HIV/AIDS and their families.[3] Physicians need to be familiar with resources in their communities that address the psychosocial and medical needs of persons with HIV/AIDS and that support the efforts of caregivers.

The purpose of this study was to identify ways in which physicians in rural and nonurban settings can better meet the needs of caregivers for persons with HIV/AIDS.

Methods

After reviewing the literature, we developed a questionnaire for caregivers and submitted it to the University of Minnesota Human Subjects Committee for review and approval. The questionnaire asked caregivers about demographics, sources of information about HIV/AIDS, caregiving responsibilities, training, challenges, relationships with health care providers, unmet needs, and financial concerns.

Once the committee approved the questionnaire, we obtained 15 names of caregivers through two agencies that serve persons with HIV/AIDS: the Duluth Community Health Center and the hospice at St. Mary's Medical Center in Duluth. We reached 14 of the caregivers, all of whom agreed to be interviewed. Interviews—conducted in July and August 1994—lasted two to three hours. We held them either in the caregiver's home or at a public place.

The sample population ranged from 25 to 75 years of age. The average age was 45. All interviewees were Caucasian. Seventy-nine percent of the caregivers were female. Thirty-six percent of the caregivers were parents of the person with HIV/AIDS, 36% were siblings, 21% volunteers, and 7% spouses. Eight were former caregivers, and six were current caregivers. Forty-three percent of the people interviewed had been caregivers for more than three years. Fifty percent of the caregivers provided care in their home. The majority (93%) of the persons with HIV/AIDS were male.

We analyzed the data, and, based on the results of the needs assessment, author Heather Chial developed a support group for caregivers in conjunction with the Duluth Community Health Center.

Results

We report on data gathered in five categories: caregiving responsibilities, caregiving challenges, finances, relationships with health care professionals, and caregiver support needs.

Caregiving responsibilities

Although the time caregivers spent in the caregiving role varied from day

to day, 71% reported spending more than 15 hours per day in that role when the person they were caring for was acutely ill.

All caregivers interviewed described companionship as their primary role. Other responsibilities included personal care (71%), errands (64%), food preparation (57%), housekeeping (29%), and social services (21%).

Most caregivers (92%) felt medical personnel had provided them adequate instruction to function as home health aids. The majority were comfortable using universal precautions (93%), administering medications (100%), and responding to unknown medical situations (100%).

Caregiving challenges

While caregivers indicated that their experience was very rewarding and worthwhile, they described caregiving itself as "very stressful" at times. The unpredictability of AIDS created a major source of stress for all caregivers interviewed. Many compared the experience to the ups and downs of a roller coaster ride.

Specific symptoms that caregivers found most difficult to manage were dementia (36%), psychological changes (36%), diarrhea (29%), reactions to medications (21%), Kaposi sarcoma (7%), and CMV retinitis (7%). All caregivers living with the person with HIV/AIDS noticed changes in mental function. Seventy-nine percent reported the person they were caring for had experienced confusion or memory loss.

All of the caregivers found it very difficult to watch the physical and mental decline of the person with AIDS and realized their efforts would not change the course of the disease. However, many found strength in the fact that they were doing all they could. Many of the caregivers indicated they would not have any regrets when the person with HIV/AIDS died (43%), and many (36%) found close contact with the person with AIDS, often a loved one, to be very rewarding.

Finances

Financial issues created stress for 43% of the caregivers interviewed. Ten of the 14 caregivers indicated that the person they cared for had difficulty paying for basic living expenses, including food (60%), rent or mortgage (40%), health care (40%), medications (10%), and transportation (10%).

Relationships with health care professionals

The majority of caregivers were satisfied with the quality of medical care their loved ones had received. Caregivers described physician qualities they thought were important, including humanity, compassion, cultural sensitivity, and listening skills. Caregivers relied on physicians for education about the disease and what to expect.

When asked what important aspects of HIV/AIDS they wanted medical personnel to be sensitive to, caregivers repeatedly responded, "Treat the whole person, not just the disease." Eighty-six percent of caregivers said they wanted medical personnel to recognize them as members of the care-providing team. Eighty-three percent felt they had been treated as team members. To maintain a team approach, caregivers suggested that health care professionals acknowledge the caregivers' role, listen to them, keep them informed, sponsor conferences on the subject of caregiving for persons with AIDS, and be aware of community resources.

Caregiver support needs

None of the people we interviewed had been involved in support groups for caregivers. Eighty-five percent felt they would benefit from such a group. Eighty-eight percent of these caregivers preferred a structured format with group discussion. Topics of interest included hospice care, what to expect, coping responses, financial management, end-of-life issues, homosexuality, and home health aide training.

Discussion

This study is one of the first to evaluate how physicians in rural and nonurban settings can better meet the needs of informal caregivers for persons with HIV/AIDS.

The caregiver roles and responsibilities we describe resemble those of caregivers in urban settings. In a study of caregivers in urban areas by Ward and Brown, the caregivers said that providing companionship was their most common and time-consuming activity.[1] All of the caregivers in our study also identified companionship as their primary role. Other responsibilities common to caregivers in both settings included personal care, food preparation, housekeeping, errands, and social services.

The literature for AIDS caregivers in urban settings describes uncertainty as the major source of stress.[4] All of the caregivers we interviewed indicated that the unpredictability of AIDS was stressful for them as well. Brown and Powell-Cope write that "anticipatory guidance" by health care professionals can help caregivers cope with this uncertainty.[4]

The literature addressing caregivers' needs in an urban setting also reveals that the experience of AIDS can be impoverishing, regardless of the resources a person has when diagnosed.[3,5] Forty-three percent of the caregivers in our study said that finances were a source of stress. Many reported that the person with AIDS had difficulty paying for even the most basic living expenses.

Support groups have helped many caregivers for persons with AIDS. Brown and Powell-Cope feel that "support groups should be an integral part of health and social services for families affected by HIV/AIDS."[2] Support groups can reduce the feeling of isolation many caregivers experience.[6] A significant benefit of talking with other caregivers and sharing experiences is "gaining support and assistance from others ... and acknowledgment of the contribution they are making to the person with AIDS' quality of life."[2] Support groups also help caregivers and patients develop better support networks and enhance their problem-solving strategies. Finally, they give caregivers the opportunity to ask questions and discuss treatment options and available resources.[3]

None of our study's caregivers had participated in a caregiver support group. However, the majority (85%) felt a support group would

benefit them. Most preferred a structured format with group discussion.

Based on the results of our study, a support group was developed in Duluth. The group met once a week for eight weeks. The group addressed a variety of topics, including the medical aspects of HIV/AIDS, stress management, caregiving strategies, community resources, hospice care, end-of-life issues, and public reactions to HIV/AIDS. Sessions began with presentations by community volunteers and ended with group discussion. This group has since evolved into a grief support group for caregivers of persons with AIDS, and it continues to be sponsored by the Duluth Community Health Center.

Limitations of the study

The small sample population significantly limited our study. At any one time, there are approximately 60 to 70 HIV-positive persons in the Duluth area, about 10 of whom need caregiving support for their illness-related disabilities. The 15 caregivers identified to the authors for potential interviews made up the population of caregivers at the time of the study.

Implications for Physicians

Physicians play an important role in educating caregivers and providing persons with HIV/AIDS and their caregivers access to available health and social services. Therefore, physicians need to be aware of community resources. The caregivers in our study relied on physicians to educate them about HIV/AIDS, about caring for the person with HIV/AIDS, about that person's medical needs, and about what to expect. Rural and nonurban settings have fewer resources than urban areas. Physicians in rural settings play a greater role in educating caregivers about local services. Physicians also play a more active role in creating or participating in community programs such as the support group that author Chial developed.

One of the caregivers stated, "We are all AIDS affected." When a family member becomes ill, the whole family, including the caregiver, is involved physically and emotionally. Taking a holistic approach when treating AIDS patients is essential, particularly in rural and nonurban settings where support networks and other resources may be less developed. Regular communication between physicians, patients, and caregivers has a significant impact on patients' quality of life. We recommend interdisciplinary teams, which would, ideally, include caregivers, physicians, and others involved in treating or caring for AIDS patients. MM

Acknowledgments

Portions of this article were presented at the Minnesota Academy of Family Physicians in May 1995, where it was recognized as the year's best medical student research effort.

The study was funded through a grant from the Department of Health and Human Services Public Health Service, Health Resources and Service Administration, Bureau of Health Professions Grant #5D15-PE80026.

Heather Chial is a fourth-year medical student at the University of Minnesota Medical School. Barbara Elliott is an associate professor in the Department of Family Medicine at the University of Minnesota–Duluth School of Medicine, where Chial received her first two years of medical training.

References

1. Ward D, Brown MA. Labor and cost in AIDS family caregiving. West J Nurs Res 1994;16(1):10-25.
2. Brown MA, Powell-Cope GM. Going public as an AIDS family caregiver. Soc Sci Med 1992;34(5):571-80.
3. Katoff L. Community-based services for people with AIDS. Prim Care 1992;19(1): 231-43.
4. Brown MA, Powell-Cope GM. AIDS family caregiving: transitions through uncertainty. Nurs Res 1991;40(6):338-45.
5. Glick Schiller N. The invisible women: caregiving and the construction of AIDS health services. Cult Med Psychiatry 1993; 17:487-512.
6. When HIV hits home. Harvard Health Letter 1994;19(6):1-3.

"Central Washington isn't wet like Seattle. It's sunny and dry with many lakes and rivers. Orchards are everywhere."
Laurence Lee, M.D.



WASHINGTON

The Wenatchee Valley Clinic, a prominent 140+ physician, multi-specialty group practice in the Pacific Northwest has several practice opportunities throughout its practice locations. Currently, we are seeking:

WENATCHEE
• Family Practice w/ OB • Pediatrician
• Neurosurgeon • Infectious Disease
• Radiation Oncology • Cardiologist
• Pathologist

OMAK/MOSES LAKE
• Family Practice w/OB • Obstetrician
• Ophthalmologist • General Surgeon
• Dermatologist • General Internist
• Gastroenterologist • Urgent Care

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Send C.V. to the attention of Fred Bockenstedt, M.D., Medical Director

P.O. Box 489, Wenatchee, WA 98807
FAX (509) 664-7178
CALL (509) 663-8711 ext. 5203

Wenatchee Valley Clinic

ASPEN Medical Group

Family Practice
Internal Medicine
Full-Time Urgent Care

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.

3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Austin Medical Center

Family Practice

Opportunities available for board certified/board eligible physicians.

also

Emergency Room/Urgent Care

Opportunities available for ER trained or FP with ER experience.

Austin Medical Center is a comprehensive, 36-physician medical facility which offers primary care, specialized care, hospital services, home health care, and hospice.

Our excellent compensation package includes guaranteed first-year salary, bonuses, health, disability, life and professional liability insurance, and pension. Please respond with C.V. or contact Elizabeth A. Thissen.

Austin Medical Center
Mayo Health System
1000 First Drive, N.W.
Austin, MN 55912
(507) 437-0474/Fax: (507) 437-0455
800-747-4770

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

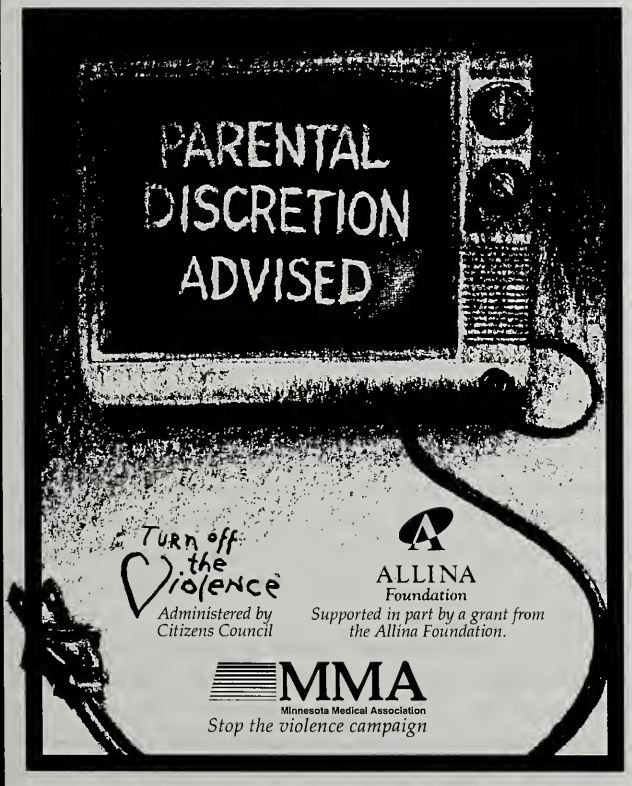
Call Stephanie Jussila, Phys. Services, for information

800•284•3142



Central Minnesota
Group Health Plan
HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220



Stop the media violence

Media violence is a health hazard to kids. As a physician, you can help by educating patients! Provide parents with information on taking charge of the media in their children's lives by limiting viewing, providing choices, and talking about what is being shown.

For further information, or to order posters and brochures to display in your office, contact:

Minnesota Medical Association
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413
612-378-1875

Screening Pregnant Women for HIV

Because available drug therapy can potentially prevent maternal-infant HIV transmission, health care providers should counsel all pregnant women regarding HIV testing.

Virginia R. Lupo, M.D.

Editor's Note: *Pregnancy is a time when a mother's actions intimately affect both the mother and her baby. Five years ago, knowing a pregnant woman was HIV positive may have had some impact on the management of her pregnancy and the newborn. Today, that knowledge can have a major impact. Identifying and treating HIV-positive pregnant women not only prolongs the mothers' lives and disease-free periods but can reduce transmission of HIV to infants by two-thirds. As knowledge changes, so must our practice of medicine. In this month's Public Health Report, Dr. Virginia Lupo tells why you should offer HIV screening to all pregnant women. Those of you who have already changed can read why you did the right thing.*

–Barbara P. Yawn, M.D., M.Sc.,
Series Editor

During pregnancy, women frequently come in contact with the health care system. Concerned with the welfare of a growing fetus, pregnant women are generally very receptive to learning about healthy behaviors. Physicians can use this opportunity to counsel pregnant women regarding HIV infection and to recommend screening. Indeed, many women are first identified HIV positive during pregnancy.

While pregnancy itself probably does not adversely affect the course of infection in the mother, infectious complications of HIV can adversely affect the pregnancy. And without treatment, a pregnant woman who is HIV positive has a 25% risk of transmitting the disease to her fetus. The recent discovery that drug therapy during and after pregnancy can decrease maternal-infant transmission of HIV by two-thirds has opened a door to preventing the spread of HIV infection.

Screening Recommendations

Currently, Minnesota does not mandate HIV testing during pregnancy; pregnant women must consent to any testing done. Unfortunately, many women do not consent because they deny they are at risk or fear a positive HIV result.

The U.S. Public Health Service has made the following recommendations regarding screening for HIV during pregnancy:[1]

1. Health care providers should ensure that all pregnant women are counseled and encouraged to be tested for HIV infection.
2. HIV testing of pregnant women and their infants should be voluntary.
3. Providers should counsel and offer HIV testing as early in pregnancy as possible.
4. Uninfected pregnant women who continue to practice high-risk behaviors should be encouraged to be retested for HIV in the third trimester.
5. The prevalence of HIV infection may be higher in women who have not received prenatal care. For women first identified as HIV infected during labor and delivery, health care providers should consider offering intrapartum and neonatal zidovudine antiretroviral (ZDV) therapy according to published recommendations.

Identifying and Treating HIV-positive Pregnant Women

Because pregnancy identifies a sexually active woman and the potential for sexually transmitted diseases, health care providers should offer all pregnant women STD screening that includes HIV testing. Screening for HIV starts with an enzyme-linked immunosorbent assay (EIA) of maternal blood. If positive, the test is repeated. When a second test is positive, a blot test is done with a test kit approved by the Centers for Disease Control and Prevention. If the blot test is positive, the patient is diagnosed HIV positive. Because HIV is a communicable disease, positive results must be reported to the Minnesota Department of Health.

HIV-positive pregnant women should be intensively counseled regarding the stage of infection and long-term treatment plans. The disease will likely affect the woman's ability to parent, and she should be encouraged to consider the issue of guardianship for her children in the event of her illness and possible death.

Health care providers should also discuss the potential for transmitting the disease to the fetus, as well as the implications of prophylactic ZDV therapy. Preliminary results from a blinded clinical trial in 1994 showed that prophylactic treatment of HIV-positive pregnant women who had CD4+ T-lymphocyte counts >200/μL with ZDV therapy orally from 14 weeks of gestation onward, intravenously during labor, and orally to the newborn for the first six weeks of life decreased the maternal-infant transmission rates from 25.5% to 8.3%.[2] This trial was the first to identify that treating an infected person with a drug therapy could help decrease transmission of the virus.

Researchers are also studying obstetrical factors affecting maternal-infant transmission rates, but results should not yet be used to alter patient management. Although transmission rates in European studies decreased with cesarean section, these studies included many different patterns of ZDV use and women at different stages of HIV infection. A large, well-controlled American study did not report such a decrease with cesarean section except when membranes were ruptured more than four hours before delivery. Currently no good evidence exists that cesarean delivery would reduce transmission if a woman is undelivered more than four hours after her membranes rupture.[3]

As with herpes infections, physicians should minimize use of fetal scalp electrodes or scalp pH sampling during labor in women who are HIV infected and should seriously weigh the benefits and risks of amniocentesis before performing the procedure.

Blind Screening in Minnesota

Infants of all HIV-positive women test positive for HIV at birth, since the IgG antibody assayed freely crosses the placenta. Since September 1988, newborn infants in the Minneapolis-St. Paul metropolitan statistical area have been blind tested for HIV if adequate blood remains on the filter paper from heelstick specimens for thyroid and PKU screening. Beginning in July 1989, the testing was expanded to include the entire state. Minnesota now has six and one-half years of data identifying the number of HIV-infected mothers, with blinding to all but county and maternal race.[4]

During 1995, 37,486 newborn babies in the Twin Cities and 21,892 from greater Minnesota were blind tested for HIV. The screening identified 24 newborns who tested positive for HIV. Twenty-two were delivered in the Twin Cities area, and two were delivered in greater Minnesota. During that same year, the Minnesota Department of Health identified 16 childbearing women as HIV infected. Therefore, the Health Department did not know of eight women delivering HIV-positive babies. Women of color in the Twin Cities represented two-thirds of the affected cases. These studies did not identify women with HIV undergoing elective abortion.

The Future of HIV Testing

If HIV was treated purely as an infectious disease, we would perform mandatory universal screening, report the results, and implement appropriate diagnosis and treatment. No state uses this approach to HIV testing, and public health agencies do not recommend or authorize mandatory screening. In 1995, the U.S. Public Health Service, the American College of Obstetricians and Gynecologists, and the American Medical Association recommended that all pregnant women receive HIV counseling and education and be offered testing. Indeed, testing for syphilis, gonorrhea, chlamydia, and hepatitis B during pregnancy is not mandatory, but the Minnesota Department of Health strongly recommends it. Tests for these infections are, essentially, universally performed.

Recently, federal legislation has mandated that by the year 2000, each state must demonstrate a 50% reduction in the number of newborns testing positive for HIV or show that 95% of pregnant women are tested for HIV. Failure to adhere to these standards will result in mandatory testing of all pregnant women for HIV on a state-by-state basis or loss of federal funding.

Hennepin County Medical Center (HCMC) has offered HIV testing to all pregnant women since 1986. Despite this long-standing protocol, only 38% of the

The MMA's Position on Screening Pregnant Women for HIV

During its 1996 annual meeting, the Minnesota Medical Association passed a resolution stating that the MMA should "... support a standard of medical care that would approach HIV like other infectious agents and AIDS like other infectious diseases." Contrary to reports in the media, the resolution does not recommend that HIV screening become a mandatory part of prenatal care delivered in Minnesota, or that HIV testing be performed on the blood of pregnant women without first seeking the patient's consent. Indeed, the association did not address the efficacy of mandatory screening of pregnant women for HIV.

The MMA has a specific policy related to HIV testing of pregnant women, adopted at its 1995 annual meeting. That policy, in keeping with current Centers for Disease Control and Prevention and Minnesota Department of Health recommendations, states: "The MMA supports the routine offering of the HIV test by Minnesota physicians to all pregnant women in their care. The MMA will disseminate this information and provide support to all Minnesota physicians." Current MMA policy regarding HIV testing reaffirms a commitment to continue to study HIV testing issues and suggests modifications of MMA policies in accordance with nationally accepted principles based on sound scientific rationale. The resolution the MMA passed at its 1996 annual meeting does not change or repeal existing policy statements.

Obstetrician/ Gynecologist

There is an immediate opening at Brainerd Medical Center for an Obstetrician/Gynecologist.

Brainerd Medical Center, P.A.

- 35-physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota

- In the middle of the premier lakes of Minnesota
- Located in central Minnesota less than 2 1/2 hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:

- Curt Nielson
  (218) 828-7105 or
  (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

Neurologist & Oncologist

There are immediate openings at Brainerd Medical Center for a Neurologist and an Oncologist.

Brainerd Medical Center, P.A.

- 35-Physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162 bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota

- In the middle of the premier lakes of Minnesota
- Located in central Minnesota less than 2 1/2 hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:

- Curt Nielson
  (218) 828-7105 or
  (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

pregnant women at HCMC in 1995 underwent testing at some point during their pregnancy. Since HCMC does not ask women to complete a checklist of potential HIV risk behaviors in which they have engaged, the actual percent of women at risk for HIV infection is not known.

Conclusion

All prenatal care providers should counsel pregnant women regarding HIV infection and recommend universal testing. Testing must, however, be voluntary, not coerced. When a pregnant woman is identified HIV positive, her health care provider must discuss the maternal-infant transmission rates and explain the potential benefits and complications of ZDV. HIV-positive pregnant women should be encouraged to seriously consider ZDV therapy. Throughout Minnesota, health care providers must dramatically increase efforts to prevent maternal-infant transmission through counseling, testing, and treatments. MM

Virginia Lupo is assistant professor in the Department of Obstetrics and Gynecology at the University of Minnesota and director of maternal-fetal medicine at Hennepin County Medical Center in Minneapolis.

REFERENCES

1. U.S. Public Health Service recommendations for human immunodeficiency virus: counseling and voluntary testing for pregnant women. MMWR 1995; No. RR-7.
2. Connor EM, Sperling RS, Gelber R, et al. Reduction of maternal-infant transmission of human immunodeficiency virus type 1 with zidovudine treatment. N Engl J Med 1994;331:1173-80.
3. Landesman SH, Kalish LA, Burns DN, et al. Obstetrical factors and the transmission of human immunodeficiency virus type 1 from mother to child. N Engl J Med 1996;334:1617-23.
4. Results of the unlinked HIV seroprevalence survey of childbearing women utilizing dried blood specimens from the neonatal metabolic screening program for 1995. Minnesota Department of Health Disease Control Newsletter 1996;24:65-72.

Informed Consent: Still a Physician's Duty

Minnesota law leaves many questions regarding informed consent unanswered, but this attorney has some advice.

Shirley Qual, J.D.

Minnesota law regarding informed consent requires physicians to disclose to a patient the significant risks and alternatives of a treatment or procedure and to obtain informed consent before the patient undergoes the treatment or procedure. When a malpractice case goes to trial, the judge will instruct the jury that a physician is negligent in failing to obtain informed consent if the following elements are proved:

- The physician knew or should have known of the risk involved in surgery or other treatment, or of the alternatives to such surgery or treatment;
- The risk or alternative treatment was significant enough that the physician should have told the patient. A risk or alternative treatment is significant if the physician knew or should have known that it would be regarded as significant by a reasonable person in the patient's position when deciding to accept or reject surgery or another treatment;
- The physician failed to disclose the risk or alternative treatment to the patient;
- A reasonable person in the patient's position would not have consented to the treatment or operation if the risk or alternative treatment had been known; and
- An undisclosed risk resulted in harm from the treatment or operation that was performed.

What Treatments Require Informed Consent?

Physicians frequently question what procedures or treatments require informed consent. The law provides no easy answer. Clearly, surgical procedures require a patient's informed consent. Thereafter, physicians are left to apply the law to their practice. For purposes of the informed consent doctrine, the courts have interpreted the term "treatment" broadly. Treatment most likely includes any type of care or procedure, and even some diagnostic tests, when the related risks and alternatives are "significant." Following are some examples.

Diagnostic tests

Many diagnostic tests trigger an informed consent discussion with the patient, and the HIV test is a classic example. Because the ramifications of HIV testing are so great and the opportunities for educating patients are significant, informed consent should be obtained from the patient before testing when HIV is included in the patient's differential diagnosis. The American Medical Association's guidelines for counseling patients before HIV testing offer a good framework for physicians developing a standard policy. (See the November 1993 issue of *Minnesota Medicine,* page 25, for an extensive discussion of those guidelines.)

Other diagnostic tests that may require informed consent include those with risks of significant injury, such as colonoscopy and angiography. On the other hand, routine tests such as white blood cell counts and strep throat cultures may not require a full informed consent disclosure under most circumstances because the risks are not significant to most patients.

Prescription medications

Informed consent may be necessary when prescribing certain medications that have significant side effects or risks associated with their use. Some medications may have very debilitating side effects, and physicians should advise patients about the risks as well as alternatives to those medications. For example, under some circumstances, the use of high-dose steroids to treat a variety of different ailments may require physicians to disclose the risk of developing avascular necrosis. Although such a risk may be slim, this side effect has devastating results when it does occur, and patients may consider alternative treatments.

What Risks and Alternatives Must Be Disclosed?

Physicians also question exactly what risks and alternatives need to be disclosed for any given procedure. Minnesota law describes a risk or alternative to be significant enough to be disclosed if a reasonable person in the patient's position regards it as such. As broad as this description is,

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Internal Medicine
Occupational Health

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES

LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell
Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
or 800-295-6373
Fax: 682-4791

the law also takes into account each patient's particular situation. Therefore, physicians should consider tailoring the informed consent discussion with each patient according to that patient's unique circumstances.

Physicians should periodically evaluate their practice of informed consent disclosure for typical invasive procedures, such as surgeries, as well as for other less invasive treatments, such as diagnostic tests and prescription medications.

How Should the Consent Be Documented?

Health care providers are often confused by the process of documenting the informed consent. "The printed consent form alone is not very useful in the defense of a malpractice claim," says Kathryn Davis Messerich, a malpractice defense attorney with the Minneapolis law firm of Bassford, Lockhart, Truesdell and Briggs, P.A. "The forms do not reflect that any informed consent discussion or disclosure occurred between the physician and patient. The preprinted forms merely relay that the patient has consented to the treatment." The most helpful documentation for a defense, according to Messerich, is separate documentation by the physician that includes the risks and alternatives discussed with the patient and a statement that the patient agreed to go forward with the treatment despite those risks.

"The closer the informed consent conversation occurs to the procedure or treatment, the more effective it can be in preventing a claim, because the patient has a better chance of remembering the substance of the conversation," says Messerich.

Conclusion

Informed consent may seem confusing, but the law is based on the medical profession's established standard of care. A common-sense approach focusing on quality patient care usually helps to unravel the difficult issues. "Physicians who approach the informed consent discussion as a legal technicality or another annoying administrative task with no real patient care purpose do not appreciate the core of the informed consent doctrine," says Marsha Studer, vice president of risk management at Allina Health System. "It is an example of best practice of medicine, which, when implemented, always improves quality of care and outcomes and ... reduces the incidence of malpractice claims."

Through the informed consent discussion, physicians can foster the physician-patient relationship by enhancing communication and engendering trust. Patients are more likely to accept a treatment they understand. Informed consent is not defensive medicine but good medicine. MM

Shirley Qual, a shareholder with the new Minneapolis law firm of Halleland Lewis Nilan Sipkins & Johnson, P.A., is a nurse attorney practicing in the area of health care law.

People and Places Making Medical News

People

Woodbury Health Care Center CEO

Julie Schmidt has been named chief executive officer of a new Woodbury health care center that Allina Health System, Children's Health Care, and HeathEast will jointly plan, own, and manage. Before her appointment, Schmidt was vice president of regional services at Allina, providing leadership support to Allina's 14 nonmetro hospitals. A registered nurse, Schmidt received her masters in business administration from the University of Minnesota Carlson School of Management.

The health care campus, known as the Southeast Quadrant Project, will be located west of Interstate 494 between Valley Creek Road and Lake Drive in Woodbury. Construction is scheduled to begin in early 1997, with completion of the first phase expected in fall 1998. The campus will include several primary and specialty care physician clinics, outpatient care, and a 70- to 100-bed community hospital.

APHA's Sedgwick Memorial Medal

Leonard M. Schuman, M.D., of Edina, Minnesota, has received the American Public Health Association's Sedgwick Memorial Medal. Schuman, emeritus professor of epidemiology and Mayo professor of public health at the University of Minnesota's School of Public Health, was recognized for his contributions to the study and application of epidemiological principles during his 50-year career. The association also commended his work in shaping schools of public health, academic epidemiology, public health policy, and preventive medicine.

Caring Neighbor Award

Sister Mary Madonna Ashton has received HealthEast's 1996 Caring Neighbor Award for her work in establishing and maintaining the network of St. Mary's Health Clinics. She began doing social work at HealthEast St. Joseph's Hospital in 1949 and has dedicated her career to identifying community needs and creating safety nets for those who fall through the cracks of society.

Started in 1992, the St. Mary's Health Clinics now have 11 sites in the Twin Cities metropolitan area and accommodate more than 16,000 patient visits. Staff provide free primary and preventive health services to the working poor, children without medical coverage, families whose medical coverage is inadequate for ordinary needs, people awaiting eligibility decisions for public assistance, and the unemployed whose medical benefits have expired.

Sexual Assault Resource Service Grants

The U.S. Department of Justice has awarded Linda Ledray, R.N., Ph.D., F.A.A.N., director of the Sexual Assault Resource Service (SARS), two grants that recognize the role SARS has played in developing forensic nursing as a specialty and the SARS program as a national model. The International Association of Forensic Nurses began in Minneapolis in 1992 at a meeting sponsored by SARS, with the assistance of the University of Minnesota School of Nursing.

Ledray will use the first grant to write a manual for sexual assault nurse examiner programs, allowing hospitals and nurses to develop programs to treat sexual assault victims following the SARS model developed at Hennepin County Medical Center. The second grant will fund the writing of a training manual for rape crisis counselors and training to rape crisis centers throughout the country. SARS will also create a train-the-trainer manual.

Places

Gillette Children's Opens Outpatient Clinic

Gillette Children's Specialty Healthcare has opened an outpatient pediatric orthopedic clinic in Plymouth, Minnesota, to meet the increasing demand for services. Last year, Gillette Children's Hospital changed its name to reflect its growing diversity of services, both inpatient and outpatient, to children with disabilities ranging from cerebral palsy and epilepsy to brain and spinal cord injuries.

The new West Health Clinic marks the first time in Gillette's 100-year history that it has operated a permanent clinic separate from the hospital. Stephen Sundberg, M.D., an orthopedic surgeon, will staff the clinic.

Abbott Receives Partnership Award

Abbott Northwestern Hospital received the 1996 Hennepin County Attorney's Partnership Award for outstanding private security service in collaboration with public law enforcement. Abbott's Safety and Security Department patrols the hospital campuses of Abbott Northwestern, Children's Health Care–Minneapolis, and Phillips Eye Institute.

Minneapolis police have trained Abbott security officers in street gang identification and bike

patrol. The security department patrols the neighborhood around the hospital, provides surveillance where criminal activity is suspected, and intervenes in crimes in progress. The department is also a leader in community crime prevention. Security officers train hospital employees and neighborhood groups in crisis deescalation techniques, and they speak to students at area schools.

American Red Cross Honors Medical Examiner's Office

The American Red Cross honored Hennepin County Medical Examiner's office for its work in educating families in the options of donating tissues from their deceased loved ones. Donations include skin, bone, connective tissue, corneas, and heart valves. The medical examiner's office has encouraged more families to donate than any other agency that the Red Cross works with in a 14-state region. Between July 1995 and June 1996, 28 families donated to the program.

AIDS Action Network Receives Award

The Rural AIDS Action Network (RAAN), a Minnesota-based nonprofit that organizes volunteer support networks statewide, has received the Intensive Care for Our Neighbor Award from the St. Joseph Health System in California. The award provides $82,500 over three years. Founded in 1992, RAAN builds community support networks that raise awareness about HIV/AIDS, provides referral services to persons affected, and links people like clergy, educators, health care professionals, and legal advocates with persons with HIV/AIDS.

Socioeconomics

Fairview, University Hospitals Complete Merger

The University of Minnesota Hospital and Clinic and Fairview have merged to form Fairview-University Medical Center, the principal site for the university's medical education, research, and patient care. Under the new structure, Fairview is responsible for the care of patients and the university for its education programs and most of the medical research. Former University Hospital affiliates—Interstate Medical Center in Red Wing and Hibbing's Mesaba Clinic and University Medical Center—are now Fairview affiliates.

Fairview will pay or assume liabilities equal to $87.5 million for the University of Minnesota Hospital and Clinic. To fund the merger, Fairview has asked the city of Minneapolis and the Minneapolis Community Development Agency to be a conduit for the sale of $175 million in tax-exempt revenue bonds. As *Minnesota Medicine* goes to press, the Minneapolis City Council plans to consider the request January 27, 1997.

For 32 months, the university will cover $1 million per month in research and education costs at the Fairview-University Medical Center. Each year, Fairview will contribute 25 percent of its operating margin in excess of 3.5 percent to the university for medical research and education.

Departments will be reorganized over 18 months, and specialties will be clustered so that similar kinds of care will be offered in the same place. The medical center will have a university campus and a Riverside campus. Most inpatient medical and surgical care will be at the university campus; most behavioral, obstetrics, short-term stays, subacute care, and rehabilitation will be at the Riverside campus.

The merger brings together two large employee groups—4,000 from the University of Minnesota Hospital and Clinic and 3,100 from Fairview Riverside. A transition fund of $3.6 million—half provided by the state Legislature, half by the university—will help former university employees during 1997 if they lose salary or benefits or experience higher health insurance costs as a result of the merger.

Owatonna Clinic Joins Mayo Health System

The 28-physician Owatonna Clinic will become part of the Mayo Health System, effective later this winter. Under the agreement, Mayo Clinic will acquire Owatonna Clinic, whose physicians and health staff will become employees of Owatonna Clinic–Mayo Health System. The clinic will continue to provide a complete range of general and more specialized health care services to patients in Owatonna and the surrounding area.

Health care services for Owatonna Clinic patients will not change. Mayo Clinic will now be an option for more specialized care, but not the only option. "Patients who want to go to Mayo Clinic will find that their care will be more streamlined," said **Brian Whited, M.D.**, an Owatonna family physician and president of the clinic.

St. Mary's Medical Center, Duluth Clinic Merge

St. Mary's Medical Center in Duluth and the Duluth Clinic have combined to form St. Mary's/Duluth Clinic Health System. With 25 medical facilities in three states, the new system is the largest private employer in Duluth. St. Mary's, which was part of the Benedictine Health System, will maintain its partnership with Benedictine as a 'sponsored organization.'

Sister Kathleen Hofer, former chief executive of St. Mary's, is board chair, and **Peter Person, M.D.**, former chief executive of the Duluth Clinic, is CEO of the new system.

Health Care Data Groups Merge

The Health Outcomes Institute and the Foundation for Health Care Evaluation joined January 1 to

EQUIPMENT LEASING *MADE easy*



Whether you need the latest in diagnostic equipment for your exam room or a new computer for the business office, MMBR Equipment Leasing offers health professionals a truly versatile, service-oriented leasing program. *One-stop shopping.* MMBR Equipment Leasing provides a single location for the leasing funds you need, with 15 different funding sources. This ensures you're getting the best rates available. *Easy processing.* You can access to up to $125,000 from a one-page application, and get approval within 24 hours. With MMBR Equipment Leasing it's as simple as a phone call. *Plans specially developed for you.* Customized lease plans are available that provide $2,000 to $2,000,000+ at terms that fit your needs. Ask about our lease options that require no personal guarantee.



Just another equipment leasing company? Not even close. Whatever you need for your lab or office, whether you're in a start-up or established practice, MMBR Equipment Leasing makes getting it easy. For personal attention and unparalleled service, call 623-2860, or toll free 800-298-MMBR (6627).



MMBR

EQUIPMENT LEASING

MINNESOTA MEDICAL BUSINESS RESOURCES

OWNED BY MMA & HMS

Now almost all your precious possessions can be insured in one brilliant stroke with The Atlantic Master Plan. It is designed for people who have a lot more to protect that the average individual.



With the specially designed coverage for the medical professional, it offers virtually unequaled insurance protection. You get coverage for your residences, automobiles, jewelry, furs, fine arts, collectibles and watercraft. You also get increased coverage for business property and electronic apparatus and additional time to tell us about newly acquired vehicles, watercraft and other valuables.

To find out about this unique insurance plan from Atlantic Mutual Insurance Company, call MMBR at 1-800-298-6627 or 1-612-623-2860.

AtlanticMutual

The right prescription for your personal insurance.

NAME

ADDRESS

DATE

Rx

Atlantic Master Plan

This plan is administered for the members of the Minnesota Medical Association by:

The Christensen Group

MMBR

Minnesota Medical Business Resources
Owned By
MMA & HMS

MMA
Minnesota Medical Association

form Stratis Health. The new organization will assess the quality of health care by using billing data and medical records to measure outcomes.

Both Bloomington-based organizations were nonprofits. The institute had a $1 million budget and seven employees; the foundation had a budget of $5 million and 48 employees.

Del Ohrt, M.D., formerly of Blue Cross and Blue Shield of Minnesota, is the new chief medical officer, and **David Ziegenhagen** is president and chief executive officer.

City, County Health Departments Merge

The St. Paul City Council and Ramsey County Board have approved a merger of their respective health departments, effective July 1. The goal of the merger is to save money and deliver health care services more efficiently. The largest immediate savings will be the $100,000 salary of the city's public health director.

Under the plan, the city will turn over its health building at 555 Cedar Street to the county, which will manage combined clinics and other health services there. The city will also transfer $2.2 million from its tax levy to the county's levy. The agreement will be up for renewal in five years, with two 10-year options to continue.

Costs for Workers' Comp Decline

The Minnesota Department of Labor and Industry reported that in 1995, total costs for the state workers' compensation system dropped 2.2 percent from the previous year. The drop represents the first decline in overall expenses in 13 years. The department also indicated that $2.22 of every $100 of a typical employer's payroll was related to workers' compensation. That amount was 8 percent less than in 1994 and the smallest level since 1985. State workers' comp costs include employer-paid premiums for employee insurance, medical expenses to treat injured workers, and administrative and legal costs.

Gary Bastian, labor and industry commissioner, attributed the decline primarily to legislative changes in the state workers' compensation system, including a 1992 law that resulted in managed care for injured workers. In an interview in the *St. Paul Pioneer Press*, Bastian said that because the system is more efficient, "many companies have seen their workers' compensation costs drop by 20 to 30 percent."

Other factors that have combined to cut the system's costs include an increased number of insurers offering workers' comp coverage in Minnesota; across-the-board efforts to make workplaces safer; a state crackdown on workers' comp fraud; and employer incentives to act promptly on claims and get employees back to work quickly.

Allina, HealthPartners Announce 1997 Provider Contract

Allina Health System and HealthPartners have successfully completed negotiations on their 1997 hospital and provider agreements, allowing HealthPartners members access to 11 of Allina's hospitals. A new feature of the contract is a five-year participation agreement with Allina's Phillips Eye Institute, where all HealthPartners staff ophthalmologists will perform their work.

Allina, Blue Cross Settle Dispute

Allina Health System and Blue Cross and Blue Shield of Minnesota (BCBSM) have successfully settled their mediated negotiations on a two-year hospital agreement. The specific terms of the agreement are confidential. However, **Mark Banks, M.D.**, BCBSM group vice president, said, "The agreement preserves choice for our 1.6 million members by keeping Allina in our statewide hospital network at equitable reimbursement rates for Allina hospital services."

Fairview Physician Associates Joins Blue Care Network

In a five-year agreement with Blue Cross and Blue Shield of Minnesota (BCBSM), Fairview Physician Associates (FPA) has become the first care system in BCBSM's new metropolitan-area Blue Care health care provider network. The network, which Blue Cross will market to mid-sized employers, is designed to strengthen the relationship between primary care doctors, specialists, and health plans in order to provide better care for patients. Health care providers, in turn, promise per-month costs that are lower than any other BCBSM network.

FPA includes more than 700 primary and specialty care physicians, a wide range of mental health and chemical dependency providers, Fairview hospitals, home care, and pharmacies.

Four other care systems have signed letters of intent to join the Blue Care network: Children's Physician Health Organization, Aspen Medical Group, Family HealthServices Minnesota, and HealthSystem Minnesota.

Governor Orders Review of State Tobacco Stocks

Gov. Arne Carlson asked the State Board of Investment (SBI) to review companies the state invests in that derive more than 50 percent of their revenue from tobacco. The request came after months of debate over what the state should do with its tobacco stock. Given the volatility of these stocks, Carlson indicated such an investment represents unnecessary risk for the state.

As of September 30, the SBI held 9.5 million shares, or 2 percent of its total holdings, in 22 companies with tobacco connections. The total market value of the shares is $281.1 million. Philip Morris holdings comprise 59 percent of that total.

continued

New TV Ratings Announced, Criticized

The Motion Picture Association of America has announced a six-tier, age-based rating system for all broadcast, cable, and public television shows except sports and news. The ratings label children's shows "Y" for children of all ages or "Y-7" for children age 7 and older. General-audience programs are rated similarly to movies. "TV-G" indicates the show is suitable for all audiences, "TV-PG" suggests parental guidance, "TV-14" means the show may be inappropriate for children under 14, and "TV-M" identifies adult shows that may be unsuitable for children under 17.

The rating will appear in the upper lefthand corner of the screen during the first 15 seconds of each show. The symbol will reappear for shows longer than one hour. The symbols will also appear on program promotions that are 30 seconds or longer, as well as in TV listings in newspapers and magazines.

Criticism has come primarily in two forms. Many critics prefer a content-based system because an age-based system doesn't give parents specific guidelines on the degree of sex, violence, and language in a show. Under the new system, networks and syndicators rate their own programming, and critics feel an independent board that includes parents should be involved.

HealthSystem Foundation Grants to Benefit Children, Youth

The Foundation HealthSystem Minnesota approved $402,879 in grants to support projects focusing on health improvement, particularly programs targeting children. Among the projects is a $5,000 grant that gives St. Louis Park high school students a chance to develop and finance programs to improve the health of their peers.

Other grants will support oncology research, cover the cost of playground equipment, provide education and support programs at Methodist Hospital and Park Nicollet Clinic, and pay for updated dialysis equipment for Methodist Hospital's Artificial Kidney Center.

Allina Foundation Announces Grants

The Allina Foundation secured $2.2 million in dedicated trust funds, formerly held by its predecessor organizations, for grantmaking. Under terms of long-standing trusts, the funds are dedicated as follows: $303,749 for nursing education; $1.27 million for leukemia research and prevention; $52,302 to support Allina Health System; $478,415 to provide health care services to people unable to afford them; and $138,139 to meet community health care needs.

The Foundation granted $110,000 to Park House, a day center for people living with HIV/AIDS, located in Minneapolis. Carondelet Clinics, which serve low-income people in the seven-county metro area, received $93,000. A one-year, $83,415 grant was awarded to a team headed by Jesse Goodman, M.D., of the University of Minnesota to promote health care solutions to environmental problems in St. Paul's Frogtown neighborhood.

Law & Policy

Justice Department Sues 'U' for ALG Revenues, Research Grants

Year-long negotiations between the University of Minnesota and the federal government over alleged fund abuses between 1968 and 1993 have stalled, and the government has filed suit against the university. Most of the $107 million in damages the lawsuit seeks stems from ALG, the organ transplant drug the university manufactured and sold worldwide for two decades. The drug was never licensed for commercial distribution, and the government contends the university gained nearly $80 million in fraudulent sales of the drug.

The government's suit claims the university obtained about $107 million through fraudulent practices. In addition to the $80 million from ALG sales, it says the university gained $19.6 million in federal research funds obtained in part through false statements; $1.1 million for improper Medicare charges for two other unapproved drugs; $2.3 million in expenses improperly charged to a federally funded cholesterol study; $628,599 in expenses improperly charged to at least 28 other Surgery Department federal grants; and $1.8 million in illegal kickbacks to faculty doctors from Caremark home health care service.

The university filed a separate suit in December asking Minneapolis federal court to void the "exceptional designation" the university received from the National Institutes of Health in 1995, restore the school's authority over federal research grants, and declare the government's claims unconstitutional.

Fairview Must Pay $1.6 Million for Malpractice

Thomas Patnaude, who became brain damaged while being treated at Fairview Riverside Medical Center in Minneapolis, was awarded $1.6 million in damages. While receiving an x-ray for injuries from a fight in October 1993, Patnaude fell and fractured his skull, resulting in permanent brain damage. Patnaude had been drinking that evening and was standing, unsecured, while the x-ray was being taken. Patnaude has been unable to work since, but is being evaluated and is receiving therapy at the Sister Kenny Institute.

Innovations

Possis Medical Will Market Clot-Dissolving Device

Coon Rapids-based Possis Medical is the first company to win FDA approval to market a device that uses high-pressure jets of saline solution to nonsurgically destroy

life-threatening blood clots. FDA approval limits using the AngioJet Rapid Thrombectomy System to remove clots from the synthetic vascular access grafts in kidney dialysis patients. Possis expects to win approval to expand the use to coronary and other arteries by 1998.

The cost for the disposable parts of the system ranges from $800 to $1,500, but **Robert Dutcher**, the company's president, chief executive officer, and one of the device's inventors, said that the system will save money and improve patient care in the long run. "We will be able to complete the procedures faster, get patients out of the hospital faster, and eliminate costly multiple visits to the cath lab," Dutcher said in a *St. Paul Pioneer Press* article.

'U' Conducts First Liver/ Bowel Transplant

A University of Minnesota transplant team led by **Rainer Gruessner, M.D.**, completed the state's first liver/bowel transplant on **Courtney Macht**, a three-year-old from Boyd, Minnesota. Fewer than 50 liver/bowel transplants have been performed worldwide on children under 5, hospital officials said.

Macht was born with short bowel syndrome, a rare birth defect that causes an undersized or malfunctioning bowel. Another defect prevented her bowel from moving food through the body. Since early in her life, Macht has been fed intravenously. The stress of IV feeding caused liver failure. Her name was subsequently placed on the liver transplant list more than nine months ago.

Medical Research

New Drug Therapy Represents Hope for Children with Leukemia

A new combination drug therapy is curing 75 percent to 80 percent of children with T-cell leukemia. **Fatih Uckun, M.D.**, director of the University of Minnesota's Bio-therapy Institute, explained that the treatment uses up to 12 drugs in rapid succession and in a precise order before the cancer cells have time to grow resistant to all of them. Uckun indicated that the therapy requires only minimally toxic levels of drugs, which reduces the amount of illness that chemotherapy often causes.

The trial, which was carried out at 120 U.S. cancer centers including the university and Mayo Clinic, identified 651 people who had

The Perfect Fit...

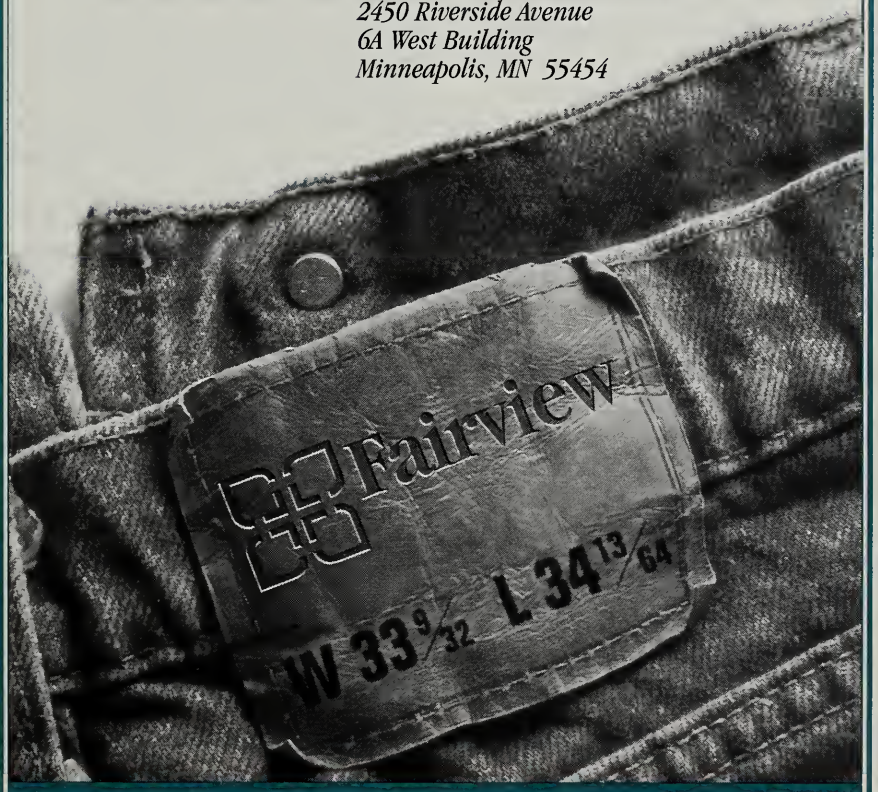
...is a rare find. Fairview Health System represents a wide spectrum of practice and lifestyle options in Minnesota. We will help you locate opportunities that are tailored to fit your needs in communities that match your size.

Opportunities now available in communities large, medium and small (and sizes in between) for...

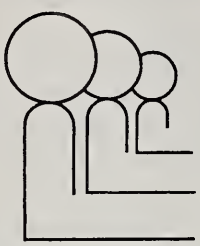
- **Endocrinology**
- **Family Practice**
- **General Surgery**
- **Internal Medicine**
- **Obstetrics/Gynecology**
- **Orthopedic Surgery**
- **Urgent Care**
- **Urology**

Fairview

Physician Recruitment & Retention Dept.
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454



612-672-2288 or 1-800-842-6469 • E-mail: fhsrecruit@aol.com



ST. CLOUD MEDICAL GROUP, P.A.

St. Cloud Medical Group,
a 38-physician multi-specialty clinic, is now recruiting BC/BE physicians in the following specialties:

- **Pediatrics**
- **Family Practice**
- **Urgent Care**

Guaranteed first-year salary. Production program thereafter with a full fringe benefit package.

If interested in joining a progressive medical clinic in central Minnesota, call or send CV to:

Daryl G. Mathews
Administrator
St. Cloud Medical Group
1301 West St. Germain
St. Cloud, MN 56301
(320) 251-8181

childhood T-cell leukemia. The 75 percent to 80 percent cure rate is compared with recently reported rates of about 40 percent.

T-cell cases represent 15 percent of the 4,000 to 6,000 childhood leukemia cases diagnosed annually nationwide. B-cell (bone marrow) leukemias constitute the rest of the cases. Success rates in the past have been lower for T-cell cancers, perhaps because T-cells evolve more quickly and become drug-resistant.

The cost of the cure is about $20,000 to $30,000 per patient, Uckun said, compared with bone marrow transplants, which range from $200,000 to $300,000. Bone marrow transplants have been used as a last resort with mixed results, said Uckun.

Heart Patients Who Smoke Can Safely Use Nicotine Patches

Researchers at the Minneapolis Veterans Affairs Medical Center (VAMC) have reported that smokers with heart disease can use nicotine patches without additional risk of heart attacks or strokes. In the largest study of its kind, **Anne Joseph, M.D.**, a physician at the Minneapolis VAMC and an associate professor of medicine at the University of Minnesota, along with colleagues at nine other VA hospitals, assigned 584 outpatient smokers with cardiovascular disease to a 10-week smoking cessation course. Half of the patients were given full-dose transdermal patches and half were give placebo patches. For both groups, the rate of heart attacks and other cardiovascular problems was nearly the same. Findings of the study were published in the December 12 *New England Journal of Medicine.*

According to **Harry Lando, M.D.**, a professor of epidemiology at the University of Minnesota who served on the federal panel that recommended using the patch "with caution," the findings should resolve fears that nicotine patches might increase the risk of heart attacks and strokes. However, the panel suggests that physicians consider waiting for four weeks after a person suffers a heart attack, a serious heartbeat irregularity, or severe angina before allowing a patient to use nicotine patches.

Screening for Childhood Cancer Proves Ineffective, Unnecessary

Infant screening for neuroblastoma, one of the most common forms of solid tumors in young children, fails to detect the most severe form of the disease, according to a group of international researchers led by University of Minnesota faculty. After screening nearly 500,000 Canadian infants for neuroblastoma, the group found that screening failed to detect the most severe forms, even though it detected twice as many cancers as had been expected. Researchers concluded that some neuroblastomas found in infant screening either go away or fail to progress. Results of the study appeared in the December 21 issue of *The Lancet.*

"Widespread infant screening for neuroblastoma does not save lives and could subject infants to unnecessary cancer treatments," said **Mendel Tuchman, M.D.**, a professor of pediatrics, member of the University of Minnesota Cancer Center, and one of three principal investigators in the study.

Deadly Strep Germs Found in Healthy Kids

Healthy schoolchildren carry the group A streptococcal bacteria that

can trigger deadly infections in adults, according to researchers at the Minnesota Department of Health and Mayo Clinic. Researchers took throat cultures from 187 pupils attending an elementary school in Wanamingo, where four adults died during an outbreak in 1995, and compared the results with throat cultures from pupils in three other elementary schools outside the area. Researchers found that 59 students in Wanamingo were carrying strep bacteria, and 46 were carrying the same strain that caused the four deaths.

"This is the first time anywhere that we were able to confirm that when you have an outbreak, it really reflects the tip of the iceberg of that strain," said Michael Osterholm, Ph.D., state epidemiologist.

Health Department Survey of Cancer among 3M Workers Dispelled

University of Minnesota epidemiologists found that death rates among 3M workers for pancreatic cancer and cancer of lymphatic tissue were not higher than those of metro area residents, as reported in a 1992 state Health Department survey. The department's investigation began in 1989 after a 3M employee complained that three of the four workers at a laboratory maintenance shop had developed cancer within a two-year period.

In their follow-up survey of 4,559 former and current 3M trades employees, university researchers found 3M mortality rates for all kinds of deaths to be comparable to the Twin Cities average. However, the study did reveal a threefold increase of colon cancer deaths among male workers in the 3M tape production department compared with Twin Cities men, and a stomach cancer death rate among women trades workers six times higher than expected.



Larry Zobel, M.D., 3M medical director, said that the company is researching case studies to determine why the cancer death rates are higher in these employee subgroups. Those studies should be completed this year.

Two-Drug Regimen Improves Colon Cancer Survival Rates

A postsurgical six-month chemotherapy regimen, containing the drugs 5-fluorouracil (5FU) and low-dose leucovorin, is effective in preventing tumor relapse and improving survival rates in patients with high-risk colon cancer, according to a study that appeared in the January *Journal of Clinical Oncology*. The purpose of the study, which was sponsored by the National Cancer Institute and coordinated by the North Central Cancer Treatment Group in Rochester, Minnesota, was to determine the effectiveness of the postsurgical drug regimen versus surgery alone.

Study results found that 41 percent of patients receiving surgery alone experienced a tumor relapse, compared with only 27 percent of patients who received chemotherapy following surgery. The survival rate in patients who only had surgery was 60 percent, compared with 72 percent for patients who had surgery and chemotherapy. The study also showed that, in high-risk colon cancer patients, a six-month chemotherapy regimen is an effective alternative to the more common 12-month regimen. MM

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

FEBRUARY 1997

Feb. 5-8 **Avoiding the Traps in Obstetrics and Gynecology in 1997** University of Minnesota Continuing Medical Education; Tucson Omni National Hotel, Tucson, AZ. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 6-8 **Twenty-second Annual Winter CME** Minnesota Academy of Physician Assistants and Wisconsin Academy of Physician Assistants; Holiday Inn, Duluth, MN. CONTACT: Cindy Ulshafer, 1825 Center Street, Centerville, MN 55038-9779; 612/653-4736.

Feb. 10-17 **HealthEast 1997 Winter Medical Seminar** HealthEast St. Joseph's Hospital; The Melia Playa Conchal Beach and Golf Resort, Costa Rica. CONTACT: Annette Anderson, 1700 University Avenue West, St. Paul, MN 55104; 612/232-5104.

Feb. 15-19 **Selected Topics in Internal Medicine** Mayo Foundation; Rancho Bernardo Inn and Resort, San Diego, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 19-20 **Symposium on Geriatric Drug Therapy** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 20-22 **Home Care Medical Directors Training Seminar I** University of Minnesota Continuing Medical Education; Harrah's, Lake Tahoe, NV. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 21 **Prevention and Management of Atherosclerotic Diseases** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 21-22 **Advanced Life Support in Obstetrics (ALSO)** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Feb. 23-25 **Home Care Medical Directors Training Seminar II** University of Minnesota Continuing Medical Education; Harrah's, Lake Tahoe, NV. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 23-28 **Fifth Annual Conference—Brain to Pelvis: 1997** University of Minnesota Continuing Medical Education; The Pines Lodge, Beaver Creek Resort, Avon, CO. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Feb. 28 **Seventh Annual Family Practice Conference** Duluth Clinic; Fitger's Spirit of the North Theatre, Duluth, MN.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

INFECTION CONTROL

Mar. 21 **HIV Primary Care Conference** Allina Health System, Children's Health Care, Duluth Clinic, Health East, Health Partners–St. Paul-Ramsey Medical Center, Hennepin County Medical Center, Institute for Research and Education–Health System Minnesota, Midwest Aids Training and Education Center, Minneapolis Education Center–Department of Veterans Affairs, and the University of Minnesota; The Metropolitan Conference Center, Minneapolis, MN. CONTACT: Allina Office of Clinical Education and Research, 612/992-2424.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

Videotapes: **Emerging Infectious Diseases** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

CONTACT: Rockie Odberg, CME Coordinator, Duluth Clinic, 400 East Third Street, Fifth Avenue, 2ME, Duluth, MN 55805; 218/722-8364.

Feb. 28-March 1 **Optimizing Disease Management Through Gas Exchange and Pulmonary Function** University of Minnesota Continuing Medical Education; Sheraton Crescent Hotel, Phoenix, AZ. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

MARCH 1997

Mar. 1-8 **Ramsey Medical Society Winter CME Conference** Ramsey Medical Society; Sheraton Resort, Xtapa, Mexico. CONTACT: Jennifer Stendahl, Ramsey Medical Society, PO Box 131690, St. Paul, MN 55113; 612/362-3701.

Mar. 6-7 **Current Issues in Phlebotomy and Point-of-Care Testing** Mayo Medical Laboratories; Renaissance Harborplace Hotel, Baltimore, MD. CONTACT: Kathy Bates or Julie McAdams, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Mar. 7 **Osteoporosis Conference** Hennepin County Medical Center; Doubletree Grand Hotel, Bloomington, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Mar. 7-8 **Advanced Trauma Life Support Course** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Mar. 13-14 **Research Statistics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Mar. 14 **Anticoagulation Therapies** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 14-15 **Current Issues in Cancer Prevention, Detection, and Treatment** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 21 **New Approaches in the Treatment of Addictive Disorders** University of Minnesota Continuing Medical Education; Sheraton Inn–Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

APRIL 1997

Apr. 4 **Case Studies in Cardiac Arrhythmias** University of Minnesota Continuing Medical Education; Earle Brown Heritage Center, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 4 **Fifty-fifth Annual Course in Allergy and Clinical Immunology** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 4-5 **Innovative Concepts for Stroke Care: Preparing for the 21st Century** St. Luke's Hospital and Regional Trauma Center; Holiday Inn, Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Apr. 9 **Emerging Infectious Diseases** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 10-12 **Hip and Knee Reconstruction: Controversies and State-of-the-Art** Mayo Foundation; The Pointe Hilton at Squaw Peak, Phoenix, AZ. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 10-12 **Home Care Medical Directors Training Seminar II** University of Minnesota Continuing Medical Education; Surf and Sand Hotel, Laguna Beach, CA. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 11-12 **Annual Ophthalmology Course** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 17-18 **Research Statistics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., February 15 for April ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Family Physicians: Friendly, growing, well-established south suburban Minneapolis family practice group seeks associates part/full time to staff day clinics in Bloomington, Burnsville, Eden Prairie, Edina, Lakeville, Mall of America, and/or Savage. Excellent call schedule, salary, and fringe benefits. Contact Administration, Quello Clinic, Ltd., 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary $80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Edina, Lakeville, Bloomington, and/or at the Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/95-R)

Olmsted Medical Center is seeking BC/BE physicians in the following specialties: emergency medicine and family medicine. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. Positions currently open include emergency room and family medicine departments in Rochester and branch office locations. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes nine branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (5/96-R)

Fergus Falls Medical Group is expanding its 33-physician multispecialty clinic and is seeking physicians in the following specialties: dermatology, family practice, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (1/97-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice-trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Rent Our Caribbean-Shore Home—Silver Sands, Jamaica. Cook, maid, your own pool. Sleeps eight. Great for families, groups. Rent from $1,995/week winter, $1,395 off-season. 800/260-1120. (10/96-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Physician Needed to work part time in multidisciplinary clinic. All calls confidential to doctor's private line, 612/889-5973. (6/96-R)

Part-time Neurologist wanted for multidisciplinary office, no call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Near Twin Cities: Community psychiatry with emphasis on child and adolescent populations. Practice offers highly qualified colleagues, a multidisciplined approach, beautiful facilities, competitive salary and benefits programs. Community offers impressive growth, good school choices, convenient access to the Twin Cities, many nearby lakes, and safe neighborhoods. Contact Verne Meyer at 800/967-2711, or E-mail delacore@hutchtel.net, or fax 320/587-7252. 2-2/97

Vacation Home Rental: Big Island of Hawaii. Elegant, secluded, three-bedroom home in North Kohala Mountains overlooking ocean. Spectacular hiking, golf, bicycling, horseback riding nearby. Rental weekly, monthly. Call 612/433-5443. 2-2/97

Emergency Medicine: Full-time and moonlighting positions available at Lakeview Hospital in Stillwater, Minnesota. Eight thousand patients per year, low acuity, excellent back-up and remuneration. Great opportunity for emergency medicine or family practice residents to pick up added income and experience. Also, multispecialty group looking to add third ED/urgent care physician. Contact Tom Monahan, M.D., Stillwater Medical Group, P.A., 612/439-1234. 2-2/97

M.D. Needed Part-Time

If you have an interest in natural medicine and the freedom to offer consultations off-site, we would like you to consider working with us for at least 3-4 days a year.

Our previous physician has retired and we have need for a medical doctor to provide physician consultations as part of our health education program.

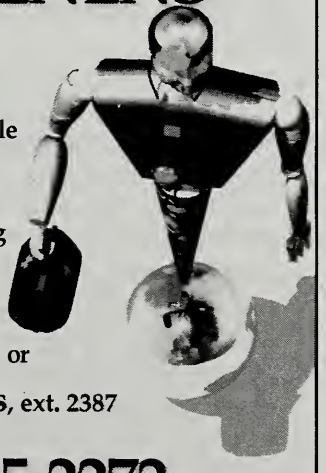
This is an opportunity for you to learn about the Maharishi Vedic Approach to Health® program which uses the principles of the Maharishi Ayur-Veda® program. Compensation is approximately $125 per patient hour. You would also be paid $250 and full tuition to attend a two-hour physician orientation program before offering the consultations. The schedule for consultations can be adopted to your current work schedule.

Please call or write:
Peter Vonderheide, Director
Maharishi Vedic School
266 Summit Ave., St. Paul, MN 55102-2121
phone: (612) 225-0872
e-mail: mvusaintpaul@msn.com

® Maharishi Ayur-Veda, Maharishi Vedic Approach to Health, and Maharishi Vedic School are service marks and trade names registered in the US Patent and Trademark Office, licensed to Maharishi Vedic Education Development Corporation.

Staff Care, Inc.
"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS



- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging

Ask for:
John Moberly, ext. 2381 or
Melanie McReynolds, ext. 2387

(800) 685-2272
http://www.locumsnet.com

Staff Care is proud to sponsor *the Country Doctor of the Year Award*

Unable to place J-1 or H-1 physicians

General Internist

CentraCare Clinic, a growing 65 physician multispecialty group based in St. Cloud, MN, seeks a general internist to join an established internist at our satellite clinic in Little Falls, MN. Enjoy the support of a large multispecialty group, while enjoying the benefits of smaller town living.

Little Falls is a picturesque community of 15,000 located 30 miles north of St. Cloud and 100 miles northwest of the Twin Cities. Little Falls is the gateway to the beautiful Brainerd lakes area. With outstanding schools, affordable housing and peaceful neighborhoods, Little Falls is an excellent place to raise a family.

CENTRACare CLINIC

Please contact:
John Schnettler
St. Cloud Hospital
1406 Sixth Ave. N.
St. Cloud, MN 56303
1-800-835-6652

A Healthier Future

Southern Minnesota

*Seeking quality primary care trained or emergency medicine physician(s) to practice in **Fairmont, Owatonna and Worthington**.*

- Stellar Emergency Medicine Practice
- Full-time, regular part-time and moonlighting opportunities
- No restrictive covenants
- Fully accredited CME programs
- St. Paul malpractice insurance
- Competitive bonus, benefit and compensation packages.

ACUTE CARE, INC.

Respond to Melissa Milliken, CMSC, Director of Development, 515-964-2772, 800-729-7813 or send CV to P.O. Box 515, Ankeny, Iowa 50021.

Geriatric Health Symposium on February 17, 1997: Franciscan Skemp Healthcare, La Crosse, Wisconsin. Contact Dr. Thomas Loepfe, Franciscan Skemp Healthcare, 700 West Avenue South, La Crosse, WI 54601; 608/785-0940, ext. 6717. 2-2/97

District Medical Director: Excellent opportunity in a large multispecialty group for a board certified physician in family practice or internal medicine. This leadership opportunity is based in a northern Twin Cities suburb and requires 50 percent administrative time and 50 percent clinical care. The practice is part of a large integrated health care system and offers a competitive salary and benefits along with a generous call schedule. For confidential inquiry, please contact Jolayne Fisher, Allina Health System, 612/992-2361 or 800/248-4921, or fax 612/992-3828. 3-3/97

Family Practice: Primary care with a personal touch—that's Regina Medical Group. Our well-established group has an opportunity for a BC/BE FP with a committed, community-based practice approach to join our Hastings, Minnesota, or Prescott, Wisconsin, sites. Excellent call, salary, and benefits. Forward your CV to Mark Kapler, vice president, Regina Medical Group, 1175 Nininger Road, Hastings, MN 55033; 612/480-4219. 3-4/97

ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 29-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- PEDIATRICS
- NEUROLOGY
- ONCOLOGY
- INTERNAL MEDICINE/PULMONOLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

FAMILY PRACTITIONERS

Gundersen Clinic, Ltd., is seeking two BC/BE Family Practitioners to join our practice in the picturesque hills of northeast Iowa. West Union is part of Gundersen's regional rural network, a system staffed primarily with Family Physicians. The regional network is supported by both on-site and immediate phone consultative services (Medlink) from the 300-plus multi-specialty physician group in La Crosse, Wisconsin.

The West Union practice includes six community clinics, with the hospital and main practice located in West Union. The practice currently includes five Physicians (including a General Surgeon) and four Physician Assistants. Obstetric practice is highly desirable. Call is 1:4. Gundersen Clinic offers competitive salaries and excellent fringe benefits.

If you are looking for a practice that has all the positives of rural life, coupled with the strengths and support of a large multi-specialty teaching institution, please send letter of application and Curriculum Vitae to Frank Perez-Guerra, Manager, Recruitment, Retention and Resource Planning, Gundersen Clinic, Ltd., 1836 South Avenue, La Crosse, Wisconsin 54601; or call 1-800-362-9567, extension 6325.

Gundersen Lutheran
Care for the way you live.

Equal Opportunity Employer

1997 Eleventh Annual Door County Summer Institute—Egg Harbor, Wisconsin 9 a.m. to 12:15 p.m. daily; July 21-25: Fred Goodwin, M.D., Psychotic Disorders; Tom Kosten, M.D., Alcohol and Drug Abuse; Peter Brill, M.D., and Len Sperry, M.D., Organizational Consultation. July 28-August 1: Joanna Rohrbaugh, Ph.D., Clinical Perspectives on Women: The Development of Self; James Gustafson, M.D., Advanced Training in Brief Psychotherapy; Merv Smucker, Ph.D., Cognitive Therapy of Borderline Personalities. August 4-8: Russ Barkley, Ph.D., Attention Deficit Disorder; Phil Resnick, M.D., Forensic Psychiatry; Medical College of Wisconsin–Neurology Department, Neurology for Non-Neurologists. For more information contact Carlyle H. Chan, M.D., Summer Institute Director, Psychiatry Department, Medical College of Wisconsin, 8701 Watertown Plank Road, Milwaukee, WI 53226, or fax 414/257-7228, or E-mail http://www.mcw.edu/psych/desi.html

*1-2/97

South Dakota
Room to Grow

Just imagine...the luxury of outdoor life in a traditional practice in Mitchell, South Dakota. The clinic is seeking a fifth BC/BE FP with OB. Quality family life, low crime rate...and **No State Income Tax!** Above national average compensation and comprehensive benefit package. Call today! Or send your CV to Pam Martin, Business Manager, Mitchell Clinic, 818 W. Havens, Mitchell, SD, 57301. 1-605-996-7772



mayo

Mayo Clinic–Rochester, Department of Otorhinolaryngology, is seeking a board-certified otolaryngologist to do non-surgical practice and offers an excellent salary/benefits package, including malpractice coverage. Relocation assistance provided. For confidential information, please send a current CV to Thomas J. McDonald, M.D., Chair, Department of Otorhinolaryngology, Mayo Clinic, 200 First Street SW, Rochester, Minnesota 55905.

Mayo Foundation is an affirmative action and equal opportunity educator and employer.

STILLWATER
MEDICAL GROUP, P.A.

Be a part of a rapidly growing community in the historic city of Stillwater, MN.

An opportunity is available for a board certified physician in General Surgery in the scenic St. Croix River Valley.

- 42-physician, multi-specialty clinic, with two clinic locations in Stillwater, MN
- Comprehensive benefit package
- Excellent school system
- Ideal for families
- Located near the banks of the beautiful St. Croix River

If interested please call or send CV attention:
Liz Junker, H. R. & Benefit Specialist
921 S Greeley St.
Stillwater, MN 55082
(612) 439-1234 Ext. 327

Minnesota Medicine
AN EXCELLENT ADVERTISING INVESTMENT

Target marketing pays real dividends with your space advertising in ***Minnesota Medicine,*** the official journal of the Minnesota Medical Association.

Delivered directly to offices, hospitals, and clinics, ***Minnesota Medicine*** reaches your key clients and prospects in their business setting.

For complete advertising information contact:

Sherry Makela
Minnesota Medicine
3433 Broadway Street NE, Suite 300
Minneapolis, Minnesota 55413
612/623-2880
800/999-1875

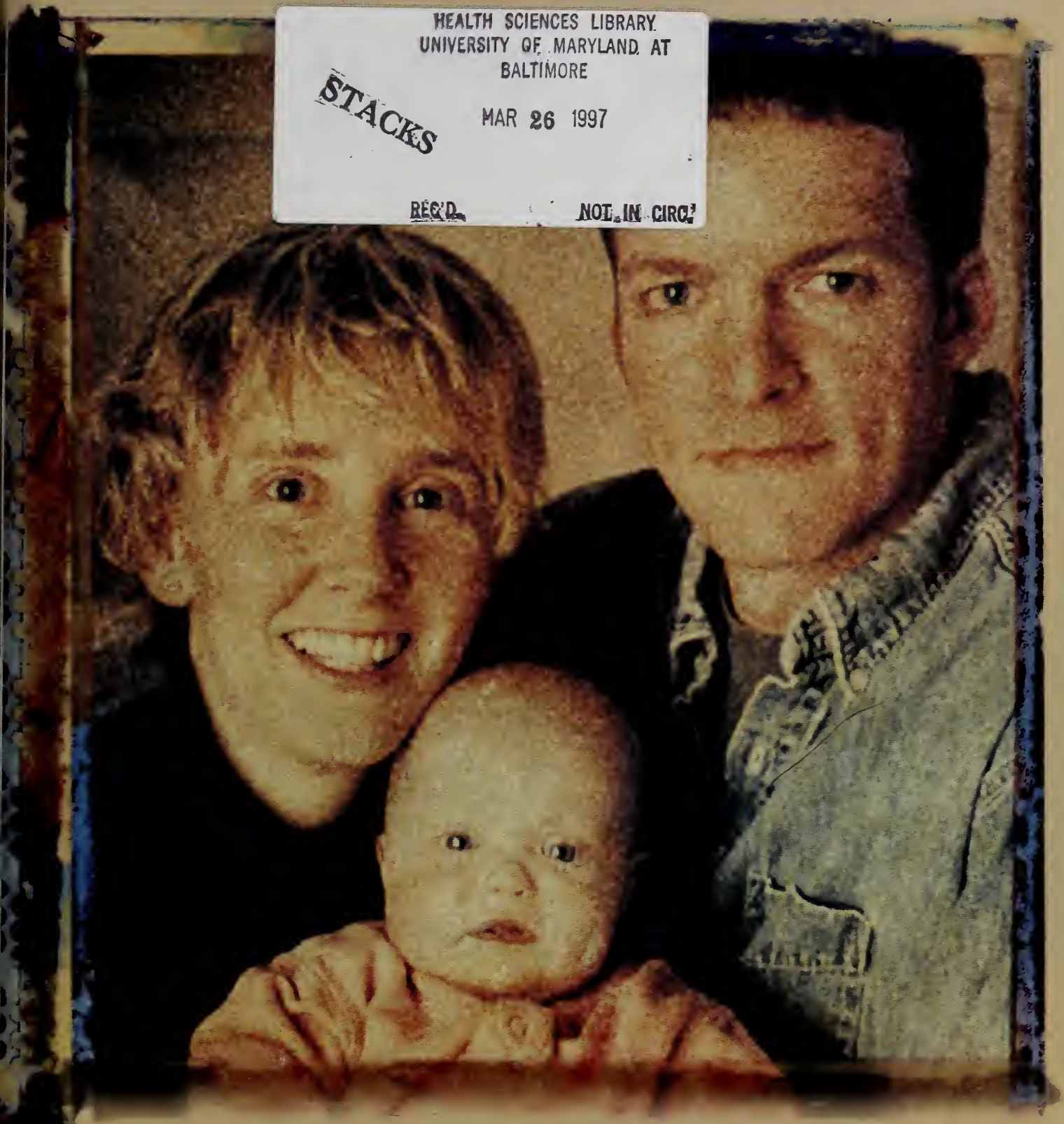
FEBRUARY 1997 INDEX TO ADVERTISERS

Acute Care Inc. 66
Affiliated Community Medical Centers 28
Air Force Health Professionals–Ft. Snelling 3
Alexandria Clinic, P.A. 66
Allina 11
Aspen Medical Group 45
Austin Medical Center 47
Brainerd Medical Center 50
Cascade Lodge 61
Centra Care Clinic 65
Central Minnesota Group Health Plan 47
Chisago Health Services 28
Fairview Clinic Services 59
Gundersen Clinic, Ltd. 66
HealthPartners 32
Maharishi Vedic School 65
Mayo Foundation 67
Medical Protective Company ..... Cover 2
MEDPAC ..... Cover 3
Minnesota Clinic 28
Mitchell Clinic 67
MMA ..... Cover 4, 47
MMBR 7, 41, 42, 55, 56
Multicare Associates of the Twin Cities 52
Navy Recruiting District 32
North Memorial Medical Programs 5
St. Cloud Medical Group 60
St. Paul-Ramsey CME 5
Staff Care, Inc. 65
Stillwater Medical Group 68
THC Minneapolis 11
Wenatchee Valley Clinic 45
Whitesell Medical Locums, Ltd. 52

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE
STACKS
MAR 26 1997
REC'D NOT IN CIRC



MOVE OVER, MEDICINE!

Today's Docs Say There's More to Life

MARCH 1997

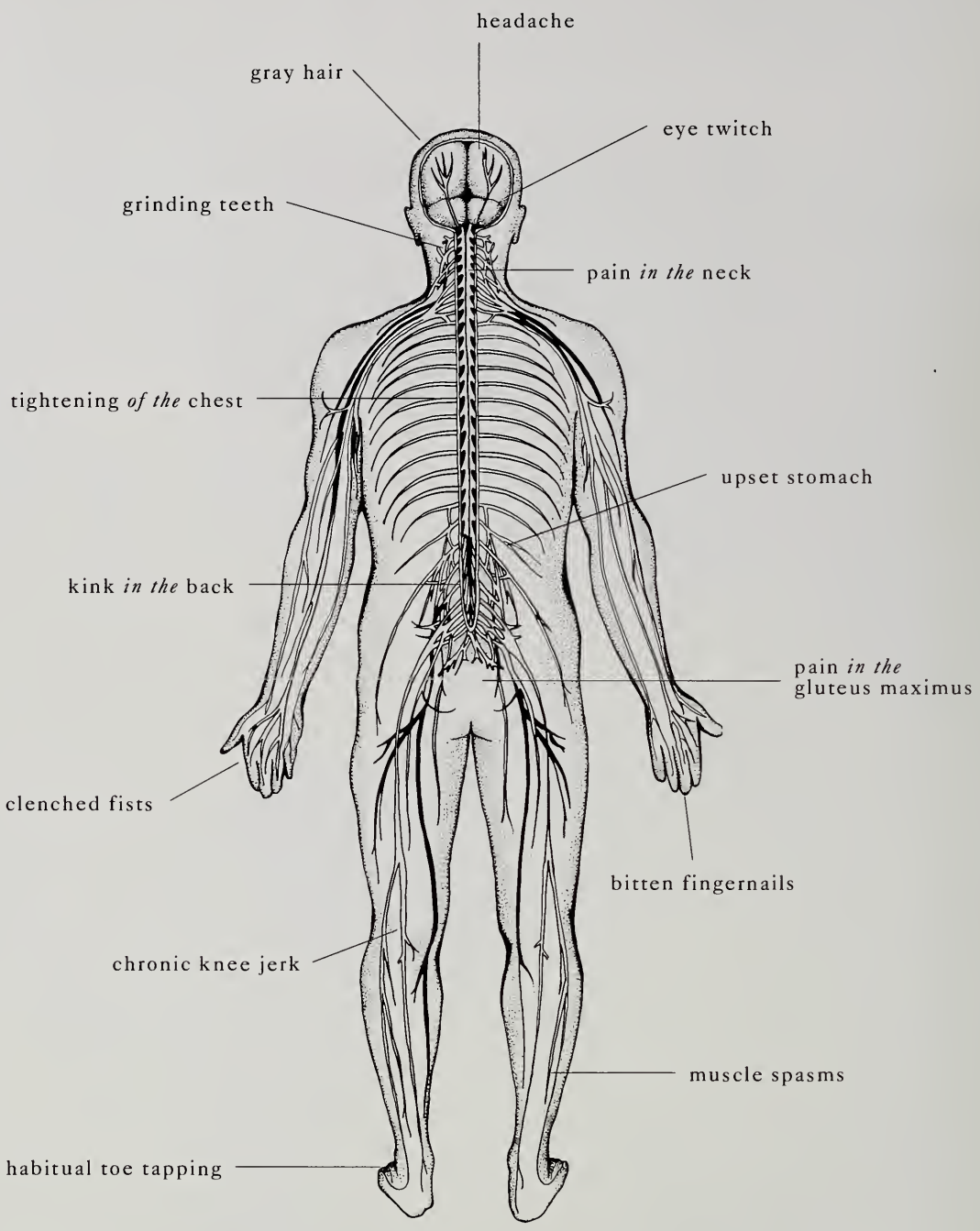


Figure 23

THE SIDE EFFECTS *of* DEALING WITH INSURANCE CLAIMS

U S WEST® CLAIMS DIRECT *and* U S WEST STATEMENTS DIRECT

Introducing a new cure for your insurance claim afflictions. With these services, all claims are processed electronically. Patient statements are then printed and mailed directly by U S WEST. Lowering office expenses and saving staff time. It's a total solution that works with all existing computer systems and software. No complicated staff training is required. And signing up is so easy, it won't hurt one bit. So give us a call. And watch your symptoms disappear, one by one.

USWEST®
1-800-654-2180

You may select from solution components independently or as a complete solution. Available to health care providers only. © 1996 U S WEST® Communications, Inc.

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Medical residents Melana Schimke and Scott Sandeno don't plan to let their medical careers interfere with family. Shown with them is 4-month-old daughter Elsa.

Cover photo by John Noltner.

DEPARTMENTS

2 ..... Editor's Notebook

3 ..... Pearls & Pointers

24 .... Author Instructions

50 .... News Clips

57 .... CME in Minnesota

61 .... Classified Ads

64 .... Index to Advertisers

FACE TO FACE

6 **The Building Blocks for Healthy Communities**

Public health advocate Beverly Propes is constructing partnerships with the Minneapolis Phillips neighborhood and health science graduate students to improve access, care, and quality of life.

PERSPECTIVES

10 **A Letter to Lara** ..... Robert R. Raszkowski, M.D.

A father and physician offers words of encouragement and wisdom to his daughter, about to embark on her medical career.

COVER STORY

12 **Move Over, Medicine!**

Today's Doctors Say There's More to Life ..... Miriam K. Feldman

Once an all-consuming profession, medicine is being transformed by a new generation of physicians seeking to balance work and family.

SPECIAL REPORT

19 **Untangling the Cost of Family Practice Residency Training** ..... John E. Kralewski, Ph.D., Kenneth Kephart, M.D., and Stacy Hakanson, M.S.

The authors propose a model that analyzes teaching costs associated with training family practice residents in ambulatory care clinics.

CLINICAL & HEALTH AFFAIRS

25 **Joint Pain and Weather: A Critical Review of the Literature** ..... Donald C. Quick, Ph.D.

PUBLIC HEALTH REPORT

43 **Impact of the 'Back to Sleep' Campaign on Sudden Infant Death Syndrome in Minnesota** ..... Patrick L. Carolan, M.D., Kathleen L. Fernbach, B.S.N., R.N., Sharyn A. Larson, B.S.N., R.N., and Junie C. Svenson, M.P.H.

Widespread use of the supine infant sleep position has reduced SIDS incidence in Minnesota and in countries throughout the world.

BOOK REVIEW

47 **Residency: A View of the Distant Destination** ... Charles R. Meyer, M.D.

"Residents: The Perils and Promise of Educating Young Doctors" and "Life After Medical School" offer insights into medical training.

33 The Monitor

Highlights ..... *MMA bill to reduce 2 percent tax has 43 sponsors • Viewpoint: Public health is high on MMA agenda • Update on MMA legislative goals • Origins of homeopathic medicine*

A New Generation of MDs

It's a sign of aging to find yourself on the other side of a generation gap. This phenomenon was born in the '60s and colorfully described the attitude differences between World War II parents and their Vietnam-hating kids. For a couple of generations, the medical world seemed spared the schism between young and old. During the '50s, '60s, and '70s, most new doctors emerging from the tar pits of medical school wanted what their forebears wanted—a busy practice, professional respect, and a comfortable income. Now the generation gap has hit medicine. Medical school grads have career ideas that furrow the foreheads of their forebears and portend a whole new culture for the practice of medicine. Young docs, what they want, and what they're getting, is this month's theme.



"Do the priorities of today's new physicians imply anything about how they will practice medicine?"

Contrast the "traditional" career Robert Raszkowski, M.D., describes in a letter to his graduating medical school daughter (page 10) with the professions of present-day practitioners in our cover story (page 12). Raszkowski speaks eloquently about the rewards of 40 years of practice. Although acknowledging differences in today's medical practice, he endorses the professional priorities of his generation of doctors. He never once mentions family. The fledgling doctors interviewed for our feature reiterate Raszkowski's commitment to patients, but family and nonmedical pursuits figure prominently in their career calculations. In short, these docs are saying, "Get a life!"

The mental metamorphosis of recently trained doctors has been swift, accelerated by demographic changes in the medical student pool, by the health care delivery revolution, and by shifting societal values. Entering medical students are older and less male than 20 years ago. The era of health care megaliths and vertical integration has dawned since 1977. During that same time, two-income families with their frantic, time-juggling act have boomed. These are different people facing a different world.

These difference have already had an impact on the practice of medicine. In 1995, 45.4 percent of practicing physicians were employed by a large organization, compared with 25 percent in 1983. New physicians are seeking a secure income with capped time commitments.

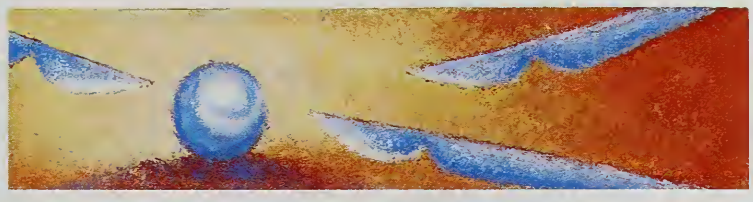
Yet look beyond the contracts these new doctors are signing. Do the priorities of newly emerging physicians imply anything about how they will practice medicine or how they will contribute to a larger community? Do doctors with an eye on the clock maintain the same sense of responsibility for sick patients? Will physicians who horde their nonmedical time take refuge at home and never participate in the rest of society? Will this new group ever see collaboration with their fellow doctors as a social and emotional bond as well as a professional connection? Using the metaphor of sociologist Robert Putnam, will tomorrow's doctors prefer to "bowl alone" rather than join leagues?

It all boils down to commitment and involvement. Both are more mental than physical, but true mental engagement requires a certain minimum physical presence. Physicians really do have to "be there" for their patients.

All generations need to embrace the core values of medical practice: talk, teach, learn, and care. And they must see beyond their clinic notes and CBCs to the wider community that needs healing, too.

Marriage, medical career, and life are all in tenuous balance. There's only so much mental and physical time to devote to each. Yesterday's and today's physicians stare across the medical generation gap, having chosen a different balance. But a solid rope labeled "patients" connects the two sides. Tomorrow's doctors need to make sure that rope doesn't fall into the breach.

Charles R. Meyer, M.D., Editor-in-Chief



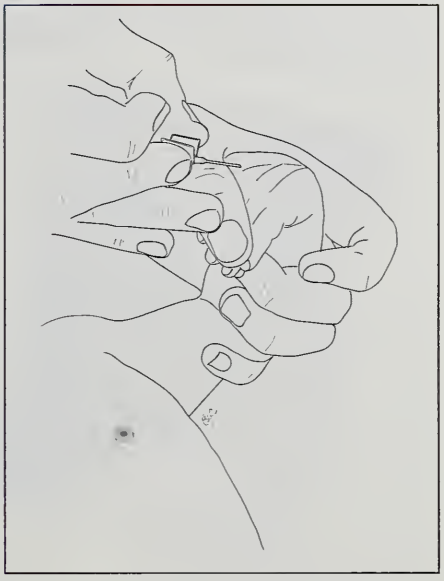
Obtaining Venous Access in Newborns

I would like to share with *Minnesota Medicine* readers a technique that I was taught many years ago as a third-year medical student at Cook County Hospital, affiliated with the University of Illinois Medical Center.

Obtaining venous access in newborns can be quite a challenge. Infants' inherent lack of cooperation, the reduced caliber in the size of their veins, and their increased percentage of body fat (16 percent of body weight in the average full-term infant) can make finding and catheterizing their veins difficult.

To make this task less challenging, position the infant's hand as shown in the figure to stabilize both the dorsum of the hand and the intended vein. Then use your second, third, and fourth fingers as an intermittently compressing tourniquet to increase blood flow. This simple technique has served me well through the years and frequently allows me to draw blood from infants without any additional assistance. MM

Submitted by Richard C. Lussky, M.D., assistant medical director of the Newborn ICU at Hennepin County Medical Center in Minneapolis, professor of clinical pediatrics at the University of Minnesota, and a member of the Minnesota Medicine *Advisory Committee.*



Figure—Infant's hand positioned for venipuncture using a 23-gauge butterfly needle.

HealthPartners
St. Paul-Ramsey Medical Center

CME
640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

CONTINUING MEDICAL EDUCATION
1997 WINTER/SPRING CONFERENCE SCHEDULE

Family Medicine Today ..... March 20-21
Annual Occupational Medicine Update ..... March 21
Agricultural Medicine ..... April 2
Annual Obstetrics & Gynecology Update ..... April 3-4
Annual ENT Update ..... April 4
Critical Care 1997 ..... April 17-18
NIOSH-Approved Spirometry ..... April 30-May 1

INFORMATION AND REGISTRATION:
Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612-221-3992 • Fax 612-292-4773

St. Paul-Ramsey Medical Center/Ramsey Clinic/Ramsey Foundation are Members of the HealthPartners Family of Health Care Organizations

HealthPartners
RAMSEY

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Consulting Editors
Lenore Franzen
Susan Rodsjo

Publications Assistant
Juliet Ramotar

Public Health Reports Editor
Barbara Yawn, M.D., M.Sc.

Graphic Designer
Michael May

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine.* The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/DIAL MMA (342-5662).

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine.* Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1996-97 Officers

President
Raymond G. Christensen, M.D.

President-Elect
Kent S. Wilson, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Paul R. Hamann, M.D.

Secretary
Judith F. Shank, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Anthony C. Jaspers, M.D.

Vice Speaker of the House
Blanton Bessinger, M.D.

Past President
Michael J. Murray, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Trinky Pollard

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth Crabb, M.D.
Theodore L. Fritsche, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875.

E-mail: mma@mnmed.org

Web site: www.mnmed.org

CONTINUING MEDICAL EDUCATION

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

MARCH, 1997

1 COMMON RETINAL PROBLEMS
Presented by: VitroRetinal Surgery, P.A.
Location: Wyndham Garden Hotel, Bloomington

7 CREDENTIALING CONFERENCE
Presented by: Allina Health System
Location: Hotel Sofitel, Bloomington

21 HIV PRIMARY CARE UPDATE
Location: The Metropolitan, Golden Valley

APRIL, 1997

4 CARDIOLOGY UPDATE
Presented by: Minneapolis Heart Institute Foundation
Location: Doubletree Grand Hotel, Bloomington

17 PRINCIPLES OF DIABETES
Presented by: Allina Health System
Location: Mercy Hospital, Coon Rapids

19 URODYNAMICS
Presented by: Abbott Northwestern Hospital
Location: Abbott Northwestern Hospital, Minneapolis

MAY, 1997

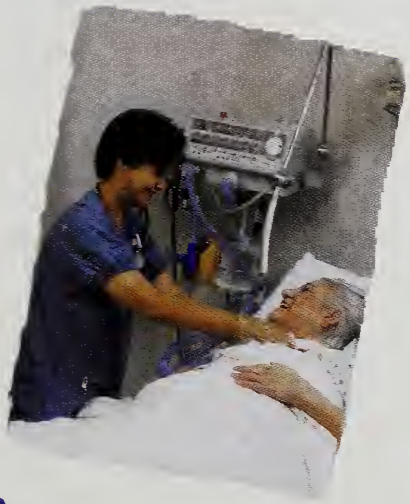
14 HEALTH CARE FOR THE UNDERSERVED
Presented by: United Family Health Center
Location: United Hospital, St. Paul

For more information, contact the Allina Office of Clinical Education - (612) 992-2424

™ A Trademark of Allina Health System

Visit the Allina Home Page at http://www.allina.com

SPECIAL CARE
FOR SPECIAL PATIENTS



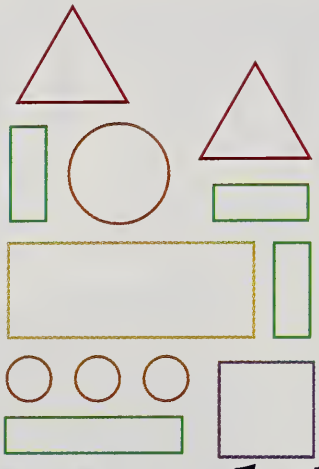
Recovery from an illness, accident or injury requires experienced medical professionals, state of the art equipment and technologically advanced therapies. It also requires a comforting, nurturing staff, a "home away from home" environment and family involvement in patient care. Our hospital is dedicated to the recovery of critically ill patients. And we're with you every step of the way, with cost effective care that includes:

- *Pulmonary/Ventilator Program*
- *Wound Care Program*
- *Medically Complex Program*
- *Low Tolerance Rehabilitation Services*
- *Early Cognitive Recovery Program*

THC · Minneapolis...dedicated to returning each patient to the most productive life possible.

THC
Minneapolis
A Subsidiary of Transitional Hospitals Corporation

621-588-2750



The BUILDING BLOCKS for Healthy Communities

Public health advocate Beverly Propes is constructing partnerships with the Minneapolis Phillips neighborhood and health science graduate students to improve access, care, and quality of life.

Five months into her new job, Beverly Propes seems right at home. As executive director of the Community-University Partnership in Education and Service (CUPES), she has found a position that calls on all of her skills. "My new job is tailor-made for strengthening the community's role in building healthy families," says Propes.

Propes's role is to organize CUPES, a four-year, $3.6 million program that will link Minneapolis' Phillips neighborhood with the University of Minnesota's Academic Health Center (AHC). The reason for the collaboration? "We want to improve the health of families in the community and provide a clinical learning experience for graduate students in medicine, nursing, public health, and dentistry," explains Propes.

A tall order by anyone's standards, but Propes, 57, seems unruffled by the challenge. Since 1980 she has built numerous partnerships in the Twin Cities that strengthen health care delivery to diverse groups and communities. The Phillips neighborhood—where she's directing her present energies—is just such a place.

Bounded by Franklin Avenue, Lake Street, and Chicago and Cedar avenues, Phillips looks like a microcosm of the world within a 1,042-acre area of Minneapolis. The neighborhood is home to American Indian, African American, Sudanese, Somalian, Southeast Asian, Hispanic, and European American people. About 80 percent of the residents live in rental housing, and the average household income is $12,000, among the city's lowest. "Despite its profile of poverty, the Phillips neighborhood is a very strong community," says Propes.

The collaboration she hopes to build through CUPES relies primarily on graduate health science students who will earn 500 hours of "urban experience" as



PHOTOGRAPH BY BRUCE BAIRD

part of their residency program. Such a residency will better prepare these students for the increasingly complex and uncharted practice models managed care is creating.

"Graduate students must first assess the community's strengths," says Propes. Experience has taught her that a person who knows and appreciates a community is more effective in addressing the community's needs and finding ways to expand its role in improving the health of its members. "Phillips residents clearly do not want another program in which they are researched, proven poor and uneducated, and then deserted," she says.

Cultural differences between health care providers and highly diverse communities can be an obstacle for programs like CUPES. Propes is well aware of the gap but anticipates it will narrow as more students of color train for health care careers. That's happened at the university, which has several recruitment programs targeted at increasing the number of health science students of color and has seen an increase in American Indian and African American medical students over the last five years.

"I hope CUPES will give some of these students an opportunity to work in a community like Phillips," says Propes. "It may mean choosing a residency position in the central community, but that can be rewarding and beneficial to physicians who practice in the 21st century."

Funded by the Kellogg Foundation and the AHC, CUPES will provide a framework within which various health care disciplines and community groups can work together. The governing board reflects this spirit of partnership; six are community members, five are university faculty.

One focal point of the partnership is Andersen Elementary School's Family Resource Center, which provides "one-stop" social services to area families. Last October, Abbott Northwestern and four HMOs—HealthPartners, MHP, Minnesota UCare, and Allina—provided funding to set up a wellness clinic there. Judy Cutler, the coordinator of the center, anticipates that CUPES will go one step further, linking nursing students to Andersen families who have chronic illnesses. "Our program uses a family systems approach," she explains. "CUPES participants will be able to meet with a family in its own environment, see the student in school, talk with teachers, and follow a child's daily care."

The list of partnerships Propes envisions is long. Dental students may spend time talking with schoolchildren about dental hygiene. Public health nurses, aware that a limited number of grocery stores in the neighborhood sell green, leafy vegetables, could discuss nutrition with American Indians, many of whom may be at risk for diabetes. Already, Propes has identified a handful of community groups CUPES could partner with: Four Winds School, Children's Medical Center–Minneapolis, United Way of Minneapolis, and clinics in the Phillips neighborhood.

Propes' background has prepared her well for the task that lies ahead. A St. Paul native, she has always wanted to give back to the community. "I dreamed of

becoming a pediatrician," she says. "My public health education extended that dream beyond children to families and community."

Propes was the first African American from Minnesota to graduate from Mayo's licensed practical nursing program. She earned a bachelor's degree in public health nursing and a master's degree in public health administration from California State University.

"My first position after returning to Minnesota was shaping the HeadStart program for the St. Paul Health Department," says Propes. "I identified key health providers, set up clinic sites within neighborhoods, and established dental and immunization protocols."

In 1976, William Norris, CEO of Control Data, asked her to set up a child care program for the company's employees. Employer on-site child care was uncommon in the mid-1970s, and what Propes developed—high-quality child development services and daily health checks by a staff nurse—became a national model.

Propes also authored a manual on sick child care that major home care service systems use. She served under Gov. Rudy Perpich as a consultant in the area of business and child care, speaking to local chambers of commerce across the country on the issue of work and family.

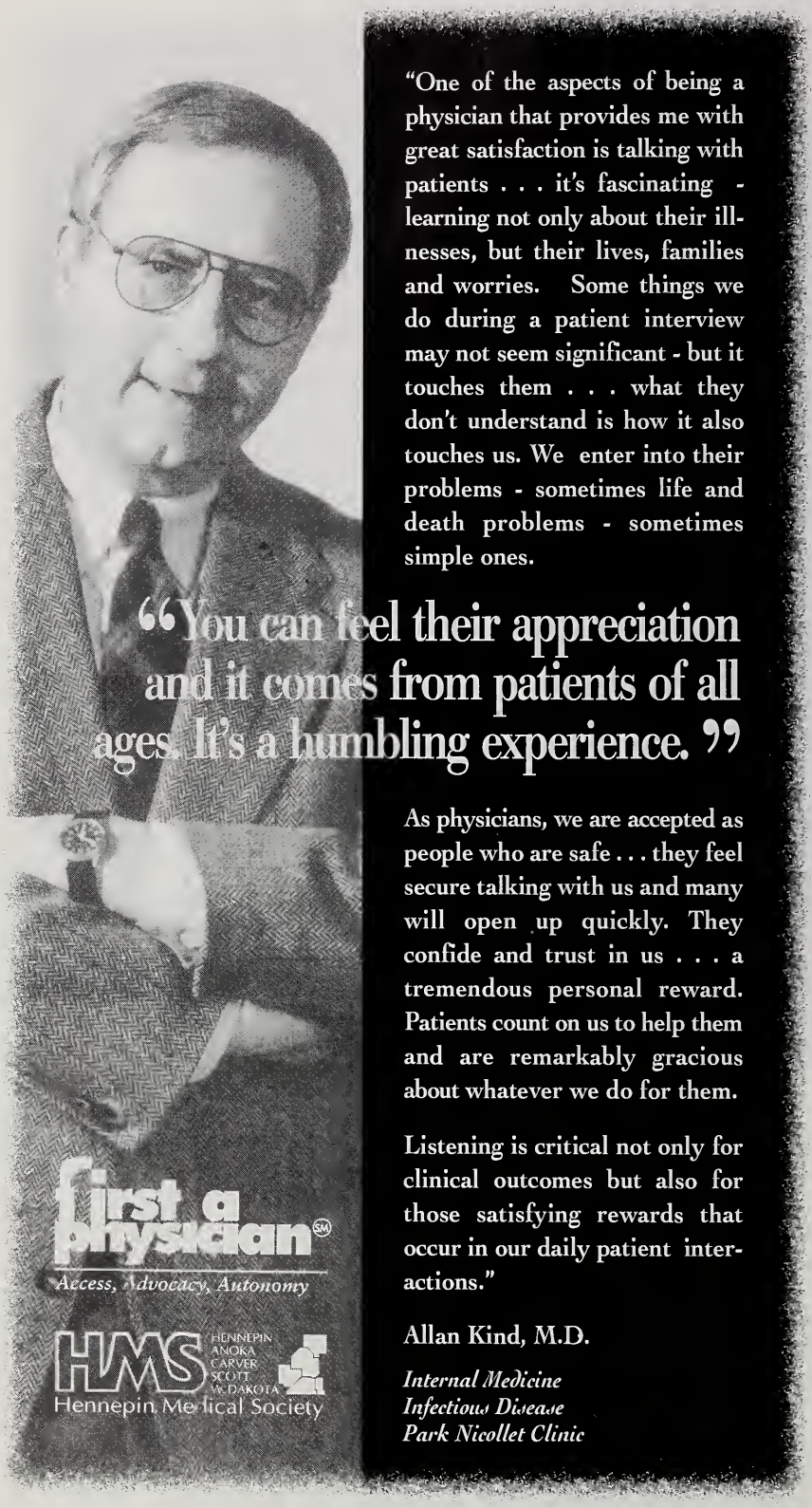
From 1989 to 1996, she served as director of community initiatives for the United Way of Minneapolis. In that capacity, she implemented and managed Success By 6®, an early childhood intervention and prevention effort to ensure learning and school readiness.

A woman more concerned with doing than being praised for what she's done, Propes has nevertheless attracted national attention. In 1994, the Minnesota Public Health Association recognized her significant advocacy in child public health. In 1995, Propes received the United Way of America Mary P. Gates Award for outstanding partnership efforts that ensure healthy child and family development. Last year, she was nominated an honorary member of the Minnesota Chapter of the National Medical Association. "I was honored to be part of the association," says Propes. "I had a dream of being a physician, and now I work with doctors to build community health."

For all that she's accomplished, Propes knows that her role in organizing CUPES will not be easy. "The challenge will be to expand existing residency programs to allow graduate students to learn from the community, its cultures, traditions, and practices, and to build on those learnings in a way that results in healthier families," Propes explains.

But optimism and enthusiasm break through when she recalls the direct impact CUPES will have on Phillips. "Somebody has to take the lead in articulating a new way to provide primary care." MM

Lynn Madsen, an independent writer based in Minneapolis, helped gather information for this article.





THE
MEDICAL PROTECTIVE COMPANY ®

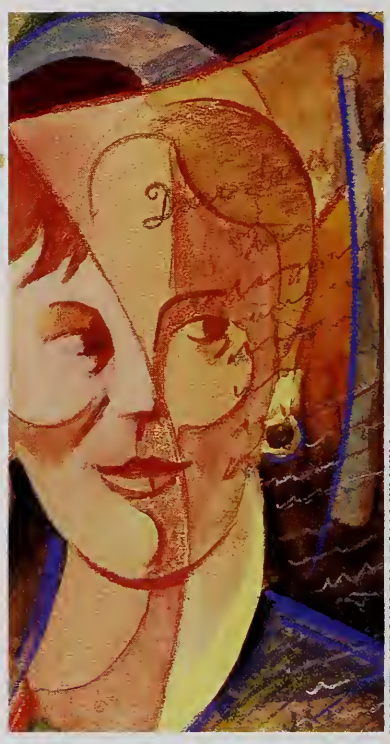
Professional Protection Exclusively since 1899

To reach your local office, call 800-344-1899.

GOLD CORPORATE AFFILIATE
MGMA
FOUNDED 1926
PROGRAM UNDERWRITER

A Letter to Lara

By Robert R. Raszkowski, M.D.



ILLUSTRATIONS BY BRIAN JENSEN

My vantage point this afternoon is a unique one, as both a parent of a member of the class and a faculty member. And it is from that dual perspective that I would like to read a letter to my daughter, to share some thoughts with her. I hope this letter might be equally applicable to anyone in the class, and, as such, it might begin Dear Cathy, or Kenton, or Brian, or Holly, or Dawn, or Tom, but this one begins:

Dear Lara,

When you started medical school I promised I would try to stay out of your education during the time you were a medical student. I hope that for the most part I have done that. But your class afforded me a unique opportunity, a cherished one, to speak to them and to you on this very special day. Here, then, are some of the things I would have said in the last four years.

First, how proud your mother and I are to be here today. We hope we have had some insight into what you put in to get here, but only you and your classmates know what it took for each of you. While your medical education may have almost fully occupied your time and devoured your resources for now and into the future, I hope you will find joy in your work. Medicine is a wonderful profession.

We are privileged to be with those we serve at the extremes of life's emotional scale: the birth of a long-awaited child, the sorrow associated with prolonged illness or an anticipated loss, the grief of a sudden, unexpected death.

Don't be afraid to show your emotions, to linger, to comfort, to hold a hand. There is no DRG or ICD-9 code for showing that you care.

Talk to your patients and remember to talk to their families, too. Osler was right. If you listen to patients and their families, they will tell you enough to make most diagnoses. While there is an ever increasing armamentarium of advanced diagnostic techniques to help you make diagnoses, the experienced clinician usually uses the history to make the diagnosis in the most cost-effective way.

Medicine is ultimately about people. Despite all the scientific advances, ultimately you and your patient come together to make decisions, and that partnership is vital. As the health care delivery system changes rapidly around you, remember that you must remain the patient's chief advocate. Do not allow your billing department, your practice group, an insurance company, an HMO, or a governmental entity to interfere with the doctor-patient

relationship. It must remain a sacred trust.

I hope you will consider becoming a teacher, not because that was my choice, but rather because medicine depends upon an apprenticeship model. Without those who gave of their time, especially the volunteer faculty throughout this state, you would not be here today. Remember to learn what not to do. Where you saw your future colleagues in medicine to be good role models, emulate them. When they weren't, remember that "25 percent of learning is learning what not to do."

And remember to teach your patients, too. That time investment will make your job significantly easier, because they will have the knowledge to become partners with you in their care.

Continue to be an active learner. You have just spent four grueling years in medical school and will spend an additional four years in a demanding residency. But hopefully, you will have the opportunity to spend 40 years in practice. And continuing medical education will need to carry you through those 40 years. Commit now to keeping your knowledge up to date.

A few weeks ago, you admitted to me that you didn't think you knew very much. That's certainly what almost all of us felt when we graduated from medical school. You're at the right place, because you recognize what you don't know. While residency and continuing education will help correct that feeling, there will always be individuals who are more knowledgeable than you. Seek them out, wherever they are, and use them as your consultants.

Be critical of yourself. On the way home at night, ask yourself how you could have done it better. Then act on your assessment the next day. In business this process is known as continuous quality improvement. To me, it's a simple way to improve your performance.

For those whom you work with and who need to change, counsel them in private and praise them in public. If you felt uncomfortable when you were belittled in a learning situation, don't perpetuate this negative part of medical education.

If you are lucky, many others will help you succeed. And when others help you do something well and you are publicly acknowledged for your accomplishments, step aside and let them have, or at least share, the spotlight.

Today's health care is more and more becoming a partnership. Many are there to help you care for your patient and add their expertise. Welcome them for what they can add, but never forget that when the iceberg is dead ahead, it will be lonely in the wheelhouse. You are the captain of the ship. Someone has to do it, and that is where your personal strength, training, and expertise will hold you in good stead.

Be quietly critical of the status quo. Advances in medicine are rarely made without questioning current doctrine. Continue to think like a scientist.

You will be held to a higher standard than most in our society and rightly so, I believe, as you will be making life-or-death decisions. Live your life and make your moral and ethical decisions as though you were living on the front page of the local paper, because in most communities you are.

Finally, try to contribute your time and your talents to your community and to your new profession. Too frequently we criticize from the sidelines. That is certainly much easier than taking risks by being a participant.

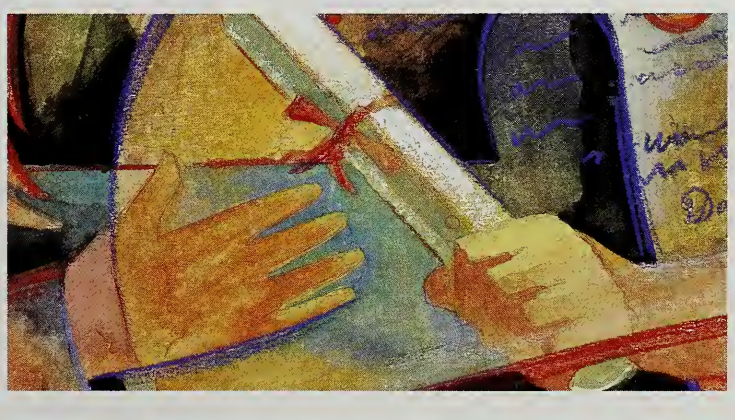
So, Lara, there it is. It turned out to be simple. Listen, care, question, accept responsibility, and share your time and your talents.

And now, on behalf of your family, the faculty, and the profession, congratulations and welcome, Doctor.

With respect and love,
Dad.

Robert Raszkowski read this letter at the May 1996 graduation ceremony at the University of South Dakota School of Medicine.

Reprinted with permission from the *South Dakota Journal of Medicine* 1996;49:409-10.



MOVE OVER, MEDICINE!

Today's Doctors Say There's More to Life



Once an all-consuming profession, medicine is being transformed by a new generation of physicians seeking to balance work and family.

Two and a half days a week. That's how often Lori Devine, M.D., practices medicine. The rest of the time she stays home with her two young children.

Devine's part-time schedule would have been inconceivable to her father, David Lamusga, M.D., who joined a small practice in Cambridge, Minnesota, 30 years ago. It would have been "somewhat disquieting," he says, to encounter a physician with her workload.

On the other hand, Devine would not have gone into medicine if she'd had to do it on her father's terms. "His hours were horrendous," she recalls. "I have no doubt that my dad is and was very well respected in the community. At the same time, I feel I'm respected for my choice to work part time."

In many ways, Devine is typical of the new generation of physicians. She is never on call, refuses to practice obstetrics, and handles outpatient medicine only. Her reason? She wants to be available to her children.

"I enjoy watching my children grow up and spending time with them," says Devine. "When I'm at work, I very much enjoy what I'm doing. I balance the two." Devine believes that the women she sees in the clinic understand the demands she faces, and that they respect her desire to be a good mom.

Devine graduated from the University of Minnesota Medical School in 1991, at a time when women were entering the profession at nearly the same rate as men. Like nearly half of all female physicians, Devine is married to a doctor. And like a growing number of physicians, male and female, she doesn't have her own practice but is an employee. She practices at Franciscan Skemp Health Care, part of Mayo Health System, in La Crosse, Wisconsin.

Devine's flexible schedule would not have been an option when her father started practice. "If we had a doctor who graduated with me and practiced only three days a week, from 9:00 to 4:30,

Story by Miriam K. Feldman

Photographs by John Noltner

we would perhaps think he was wasting what he was taught. That was my attitude," says the 55-year-old Lamusga. A part-time doctor would have been looked upon as something other than a "true physician."

But Lamusga's attitude has changed, and he's even adopted some of his daughter's ways. Not long ago, he discontinued obstetrics practice and call, although he still practices family medicine at the Cambridge Medical Center. "I am enjoying the leisure time more now," he says, "but I wouldn't say I didn't enjoy what I was doing."

What he did, of course, was the norm for physicians of his generation. "We were 24-hour people initially," recalls Elizabeth Craig, M.D., who retired in 1987 after more than 40 years in private practice. "It's very different today. People can work part time. I just felt that I was falling short if I wasn't full time."

The Generation Gap

Some "24-hour people" have trouble understanding the new breed of physician. Seymour Handler, M.D., for example, is dismayed by what he calls the "complete change in attitude" among the younger physicians in his group, North Pathology Associates, at North Memorial Medical Center.

"They don't want to do as much," says Handler, who at 67 is the second-oldest full-time practitioner on a medical staff of 700. "The discussion is so different from 35 years ago, when I came into practice. All I thought about was, 'This has got to be the most fantastic professional opportunity to ever come to me.' We never talked about money, call, hours, work mode. Physicians today talk about hours, weekend call, security, money. I don't quite know what to make of it."

The current generation of physicians does have a new attitude, agrees Mark Bixby, M.D., unit director of the University of Minnesota/North Memorial family practice residency



Melana Schimke and Scott Sandeno, with their 4-month-old daughter, Elsa, typify the up-and-coming generation of physicians. They married two years ago, after graduating from the University of Washington School of Medicine. Both are doing residencies in the Twin Cities, Sandeno in internal medicine at the University of Minnesota and Schimke at Creekside Family Practice. Sandeno will also complete a one-year chief residency at St. Paul-Ramsey before the couple returns home to the Pacific Northwest.

"People's expectations of physicians today are so high," says Scott Sandeno, noting how that can result in a depersonalized kind of medicine. "The trend of modern medicine tends to pull you away from paying attention to family and patients."



Like many young doctors, Sandeno, 29, jealously guards his time. Being with his family is a priority.

"For me, medicine is a job that I really feel fortunate to be able to do and enjoy."

program. "They really are different in their outlook on medical practice. They don't see medical practice as the be-all and end-all. They don't want to be just a doctor. They want to be a fuller human being."

Nancy J. Baker, M.D., a family physician at Ramsey Family Medicine and past president of the Minnesota Academy of Family Physicians (MAFP), puts it this way: "There used to be a point in time when a single physician was all things to all patients all the time. In general, physicians finishing training today don't feel they're able to make that commitment."

Dedicated to Work and Family

That's not to say that younger physicians are any less dedicated to the profession. While the terms and conditions of medical practice appear vastly different from a generation ago, young doctors are choosing medicine for many of the same reasons, observers say. "Their motivation for going into medicine is still primarily to help people," says Lamusga, who teaches residents in family practice. He believes the changes in attitude are normal responses to a more complex health care environment and a society in which a growing number of women work outside the home.

Similar changes are occurring in other professions, too, observes Craig. "Even attorneys today are different. The world is very, very different," Craig says, reflecting on her own experience. She was one of three women in her 1945 graduating class at the University of Minnesota Medical School. "I was a woman in a man's world," she recalls. "I came in at the worst possible time for a woman to be starting. There weren't a lot of referrals. I had to build my practice."

All that has changed, says Ken Kephart, M.D., president of MAFP and director of the family practice residency program at Creekside Family Physicians in St. Louis Park. In the last several years, about half the residents in his program have been women, many of whom have voiced concerns about balance and lifestyle issues in training programs. Those concerns have carried over into their practices, Kephart says.

There's no denying that women have been a force in introducing alternative practice styles to medicine. As a member of the American Academy of Family Physicians' committee on women, Baker conducted a number of surveys in the late 1980s to identify the concerns of women physicians. "Specifically, they talked about flexibility in scheduling, options for part-time, reduced schedules," she says.

The surveys were conducted at a time when women still worried that asking about parental leave policies would jeopardize their chances for a job, says Baker, whose 80-percent-time work schedule allows her more time to be with her family, to write journal articles, and to participate in local and national medical associations.

Women may have led the way, but men also appreciate the new flexibility. Kyle Kircher, M.D., is a third-year family practice resident at Mayo Clinic and chair of the MMA's resident physician section. He speaks of his family—his wife who is a registered nurse, and his three young children—as a priority, one that won't take a back seat to medicine. "Work can become all consuming," he says. "What physicians today do is a career, it's their job. Previously, it was looked upon as

their life. Many physicians today aren't willing to sacrifice their families or other interests for medicine."

Changes in Recruitment

In today's climate, physicians increasingly are finding they don't have to sacrifice it all for medicine. Devine, whose experience bears that out, notes that her mail is full of announcements offering flexible practice opportunities. "It's always plus or minus ob, full or part time," she says. "The ads are showing more flexibility than ever before. It used to be that nobody ever mentioned anything like that."

As a physician recruiter, John Frederick, M.D., vice president for clinic services at North Memorial Health Care, knows how true that is. "When we're recruiting someone we really want to join our clinics, then we have to be flexible," he says. "Once we've decided they're the right person for the job, we have to make sure we can make it work for them."

Frederick, who has been recruiting physicians for about 17 years, agrees that younger doctors are looking for more of a balance between their professional and private lives. But he insists that lifestyle accounts for only part of the attitudinal shift. "Don't underestimate the market," he says, referring to the hold managed care has in this state. "Minnesota has a reputation for being a very scary market to come into."

There's no doubt the realities of the marketplace have affected the outlook of younger physicians. "I don't think physicians' attitudes changed as much as the climate they're working in changed," observes Kephart. "Physicians are responding to the market. Most of the large buying groups—HMOs and the health systems—made it clear they're not interested in going out to every Tom, Dick, and Harry and negotiating a contract. So physicians have had to react to this. That's a definite change in attitude, but it's a realistic response to a current market environment."

Bixby agrees. "I don't see younger physicians as inherently different from the older doctors. Physician attitudes are reflective of society as a whole." Today's physicians are employees rather than entrepreneurs, he says. "That's a fairly big difference."

Employee vs. Entrepreneur

The magnitude of that difference was underscored in an August 21 *Journal of the American Medical Association* (JAMA) article, "Current Trends in Physicians' Practice Arrangements." A survey by the American Medical Association's Socioeconomic Monitoring System reported that the proportion of patient care physicians practicing as employees rose from 24.2 percent to 42.3 percent between 1983 and 1994. This trend affected virtually every segment of the patient care physician population and was most pronounced among young physicians.

The AMA survey also noted a trend toward more group practices. Between 1984 and 1991, the proportion of physicians in practice with eight or more doctors increased from 28.4 percent to 32.6 percent. The average number of physicians in such practices rose from 9.1 to 11.5. ⇨

"Patients once had more faith in their doctors," says Melana Schimke, 32. Even if things went wrong, they trusted you. Now if things go wrong, it's your fault."

Still, Schimke sees many positive changes in the field. She took three months off for bed rest during her pregnancy and a four-month maternity leave as well.



Initially, she plans to practice medicine part time. "I can't imagine having a family and going full time. There isn't time to do both well."

Perhaps nowhere have these trends been more pronounced than in the Twin Cities. Fewer than half of the metro area's 2,400 primary care doctors are their own boss anymore, according to a March 31, 1996 *Star Tribune* article. "In one of the most dramatic shifts in the health care system, primary care doctors in Minnesota are selling their medical practices—often to big health-care companies—and becoming employees," the story stated. Today, just 5 percent of the primary care doctors in the metro area are in solo or two-person practices, compared with 42 percent in 1979, the paper reported.

The newspaper article echoes Kephart's observations. In the past two or three years, none of the residents in his program has joined a smaller practice with an eye to becoming an owner. "They all look for the shelter of a large system," he says. "Most of them just want to practice medicine and not be too involved in the business and economics of negotiating contracts, running an office, that kind of thing. Of our residents who have graduated in the last two years, the ones who have stayed in the city have all joined large systems. Even outside the city, all but one or two have joined larger systems."

Paul E. Bowlin, M.D., has observed the same trend. "You rarely see the young physicians 'hanging out a shingle' and starting solo practice. Younger physicians go with groups or large clinics, or combinations of managed care organizations where they are employed," says Bowlin, who retired three years ago as corporate medical director for the Fairview Health System. Before that, he practiced internal medicine with a group that peaked at eight members. Now the group is down to four and having difficulty recruiting new members. "The new doctors look over at that group and say, 'I'll join a big clinic where I don't have to work that hard.' "

A small practice means hard work, as Bowlin recalls. "Physicians of my generation pretty well accepted the fact that when they went into practice, their commitment to practice would be total. Call schedules would be rigorous. The life was grueling," says Bowlin, adding, "I do not mean to complain. Everybody lived that way."

Stuart Lane Arey, M.D., certainly did. Arey, who retired in 1984 after 50 years as a pediatrician in private practice, was on call 24 hours a day, 365 days a year. "When somebody had to be sewed up, I sewed them up. Or if they needed a shot of Adrenalin for asthma, I had to go give it." Every other year a locum tenens filled in when Arey took a one-month vacation. If that person became sick, the doctor in nearby Wayzata covered.

In defense of the younger generation, Arey says, "The climate is such that they have to talk about contracts. I didn't have to. Our only concern was to try to make a right diagnosis and find the best treatment available." In that regard, he points out, there often was little he could do. "When I started practice, we had quinine for malaria, arsenic and bismuth and iodides for syphilis, tetanus antitoxin, diphtheria antitoxin, and meningococcus antitoxin. That's all the therapy we had."

Same Values, Different Roles

The modern medicine bag has much more to offer, but with the expensive new technology comes pressure to control costs. "The environment we face today demands the best patient care in the most cost-efficient manner," says Kircher. "In the past, you only had to worry about the patient's best interest. Now you're being asked to watch the bottom line."

Physicians have plenty of other new worries, as well. As Kircher puts it: "If I'm a family physician, for example, what is my role within the system? Am I expected to be a gatekeeper? Do I accept that or not? So many of us are looking at aspects of practice that didn't necessarily exist 50 years ago."

Such concerns should not be confused with a lack of professional devotion, some observers caution. "It does not mean these younger physicians are any less caring or any more greedy or any less committed to good patient care," Bowlin says. "These are natural, normal responses to the evolution of the health care environment."

Kircher, who interviewed medical school applicants for the Mayo admissions committee last year, thinks his generation's approach to medical practice is healthier for physicians, and perhaps, for their patients. "I think all of us very much feel a sense of responsibility toward our patients. But we want to take advantage of the alternatives that we have available so we don't have to sacrifice family and other interests. What I bring to my patients is a whole set of life experiences as well.

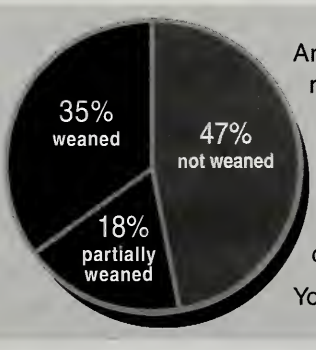
"Our first concern is being able to take good care of our patients. I hope that will never change," Kircher adds. "The same core values that drive people today were driving people to go into medicine many years ago. People want to obtain the educational training to be able to take care of people, to help people. That is at the heart of what we do, and it always will be." MM

Miriam Feldman is a free-lance writer in Minneapolis and a frequent contributor to Minnesota Medicine.



More than 1/2 of our respiratory patients are freed from ventilator dependency.

We specialize in weaning the "unweanable." With aggressive therapies, dedicated staff, and advanced techniques, our Prolonged Respiratory Care Unit (PRCU) has successfully treated the nation's most difficult respiratory cases.



And we have helped 47% of our respiratory patients go home or to home care with most cases discharged in under 28 days.

So when you need respiratory care experts you can count on, call us.

You've got our number.

Call for your free outcome report

HealthEast Bethesda Lutheran Hospital & Rehabilitation Center

559 Capitol Boulevard St. Paul, MN 55103

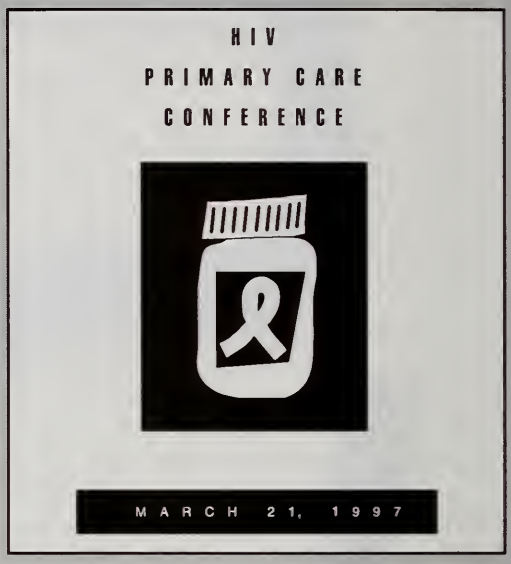
1-800-566-2720

Continuing Medical Education

Hennepin County Medical Center Activities



Advanced Life Support in Obstetrics (ALSO)
Date To Be Announced
Hennepin County Medical Center, Minneapolis
15.0 Credit Hours



HIV Primary Care Conference
March 21
Co-sponsored with Allina Health Systems
The Metropolitan Conference Center, Minneapolis
7.0 Credit Hours

Research Statistics
March 13-14 AND April 17-18
Hennepin County Medical Center, Minneapolis
12.25 Credit Hours

Exploring Biomedical Ethics
April 11
Hennepin County Medical Center, Minneapolis
6.5 Credit Hours

Osteoporosis Update
Date to be announced
Doubletree Grand Hotel, Bloomington
Approx. 6.0 Credit Hours

Annual John I. Coe Symposium
(Pathology-related, focus this year on infectious disease
May 16-17
St. Cloud Civic Center, St. Cloud
Approx. 6.5 Credit Hours

Insomnia and Psychiatric Disease: Which Came First
April 1
Presented by the Minnesota Regional Sleep Disorder Cente
Guest Speaker: Wallace Mendelson, M.D.
Hennepin County Medical Center, Minneapolis
1.0 Credit Hour

Infection Control
April 9 and June 23
Infection Control lectures, required by the MN Medical Practice Board for physicians, are offered on a continuing basis throughout the year. These one-hour lectures are held in the HCMC Pillsbury Auditorium at Noon. Please contact our office for further information.

Hennepin County Medical Center
HCMC
Level 1 Trauma Center

For further information or registration materials please contact:
Hennepin County Medical Center • Continuing Medical Education
701 Park Avenue, Mail Code 869-A • Minneapolis, MN 55415-1829
Telephone (612) 347-2075, or Fax (612) 904-4210,
or TOLL FREE 888-263-4262 (CME@HCMC)

Untangling the Costs of Family Practice Residency Training

In response to the ongoing debate over the costs of medical education, the authors propose a model that analyzes teaching costs associated with training family practice residents in ambulatory care clinics.

John E. Kralewski, Ph.D., Kenneth Kephart, M.D., and Stacy Hakanson, M.S.

For at least two decades, the debate over the true costs of medical education has been contentious. Recently, the debate has been escalated by health insurance programs that are no longer willing to pay teaching costs and by congressional efforts to reduce Medicare costs by eliminating the teaching differential paid to providers. There is widespread agreement that providing health services in teaching facilities costs more, but little agreement on the magnitude of those costs. Consequently, teaching programs are finding it increasingly difficult to cover their expenses. A 1995 study conducted by Boex for the Bureau of Health Professions reviewed 123 medical education cost studies and reports, over half of which were conducted since 1990.[1] Boex found that a wide variety of methodological approaches are being used and that the results vary considerably, depending on the methodology. He also noted that most of the studies focused on clinical education in hospitals, even though training sites are increasingly being shifted to the ambulatory care setting.

Two of the most contentious issues related to graduate medical education costs center on the effects of a teaching program on the clinical productivity of the faculty and, conversely, the trainees' contributions to the clinical enterprise. Nearly everyone agrees that third-year residents provide a great deal of patient care at a comparatively low salary, but there is little agreement on the contributions of first-year residents. How much it costs to support their mentoring and their alleged inefficient use of resources during the early stages of their learning curve are key considerations.

To address these issues in the ambulatory care setting, Boex recommends an analytic approach that focuses on patient care production costs in teaching and nonteaching clinics. He contends that analyzing costs derived from the inputs required to achieve standardized patient care outputs would identify the residual costs that logically could be assigned to teaching and would identify the areas where these costs are incurred.

While Boex's model is attractive, the measurement problems are extremely complex. Neither patient care input nor output values are readily available. We describe a pilot study that uses an input/output model to analyze teaching costs associated with training family practice residents in ambulatory care clinics. Because our study is exploratory and the measurement issues complex, only five university teaching clinics and three similar-sized community-based nonteaching clinics are included in the analysis.

Methods: Defining the Variables

We evaluated all input costs against the production of standardized patient care outputs. We constructed these standardized outputs from patient care services each clinic provided during 1993. Clinics identified the services by their CPT-4 treatment codes. We assigned these codes Medicare Relative Value Units (RVUs) to adjust clinic output for case mix differences.[2] We then added the values to obtain a total number of Relative Value Units each clinic produced during that year.

Laboratory procedures have no RVU, so we did not include them in our model. Laboratory procedures are, nevertheless, a factor in determining the cost of medical education because tests might be much higher in teaching clinics, where the trainees are still gaining experience in diagnosing illnesses. Consequently, we conducted a separate analysis of three procedures each clinic ordered during 1993. The procedures we analyzed—occult blood, cenicular vaginal cytopathology smears, and urinalysis with microscopy—all relate to a general array of illnesses commonly treated in family practice clinics and were the top three tests family practice clinics performed in-house during 1994.[3]

Our measure of laboratory use is inexact because we do not know the number of patients who might generate lab procedures in each clinic. Other variables include case mix and resident physician practice style. However, we concluded that over a 12-month period with about 22,000 patient visits per clinic and family practitioners providing all services, case mix differences should not be large.

We included two types of input data in our model:

Table 1

Costs of staff per RVU in teaching and nonteaching medical clinics

	Teaching Clinics n=5	Nonteaching Clinics n=3	T/NT
Salaries for registered nurses, LPNs, medical assistants, etc.	5.58	3.96	1.4
Telephone/telecommunications expenses	.55	.55	1.
Radiology/imaging supplies and miscellaneous expenses	.20	.56	.4
Drugs and medications	2.29	.72	3.2
General medical supplies and instruments	1.55	1.33	1.2
Laundry and linens	.12	.10	1.2
Medical and surgical supply expenses	3.96	2.15	1.8
Administrative supplies and services expenses	2.44	1.17	2.1
Outside professional fees	.26	.52	.5
Promotion and marketing expenses	.03	.39	.1
Physician compensation	34.55	19.85	1.7

detailed clinic expenses and staffing data. We collected annual expense data for the following cost centers:

- Salaries for registered nurses, LPNs, medical assistants, etc.
- Laboratory support staff salaries
- Telephone/telecommunications
- Radiology/imaging supplies and miscellaneous expenses
- Drugs and medications (other than those sold to patients)
- General medical supplies and instruments
- Laundry and linens
- Medical and surgical supplies
- Administrative supplies and services
- Outside professional fees
- Promotion and marketing
- Physician compensation.

Most of these categories are standard accounting classifications and readily available from both teaching and nonteaching clinics. However, physician input costs present two major problems. First, the university teaching clinics are staffed by full-time and part-time rotating physicians who mentor residents and provide patient care. Their salaries and benefits are set and paid by the university. In order to compare teaching and nonteaching clinic costs, we summed the teaching and patient care hours worked by clinical faculty in each teaching clinic and assigned those physicians the hourly salary and benefit values reported for physicians in the community-based, nonteaching clinics.

The second problem we faced was approximating a resident's salary, since training sites and hours spent in training vary widely from month to month for each resident. We started by determining the average annual hours first-, second-, and third-year resident physicians worked at or for their clinics. Ideally, the ratio of annual hours worked to an estimate of the total annual hours each level (year) of resident worked for the residency program (including time spent training at other sites) would have provided an approximate percentage of each resident's salary. But given the training variable, we used the average annual hours worked per physician at the nonteaching clinics instead to estimate the amount of time a resident could be expected to provide patient care

Table 2

Selected lab procedures in teaching and nonteaching medical clinics

	Teaching Clinics (n=5) Total RVUs=154,219.26 Total Patient Visits=95,336			Nonteaching Clinics (n=3) Total RVUs=121,657.45 Total Patient Visits=86,754		
	Frequency	Freq/RVU	Freq/Patient Visits	Frequency	Freq/RVU	Freq/Patient Visits
1. Occult blood (CPT-4 code: 82270)	461	0.003	0.005	1,733	0.014	0.020
2. Cytopathology, smears, cervical or vaginal (CPT-4 codes: 88150, 88155, 88156)	4,844	0.031	0.051	4,782	0.039	0.055
3. Urinalysis with microscopy (CPT-4 code: 81000)	2,572	0.017	0.027	4,812	0.040	0.055

at various training sites throughout the year (1,706 hours per year per physician). We multiplied a resident's total salary by the percentage of resident time spent specifically in teaching clinics. The result approximates residents' salaries in teaching clinics. We then added these estimates to the faculty compensation data to obtain total physician compensation expenses at the teaching clinics. Our methods undoubtedly inflated the teaching clinics' costs somewhat but helped us standardize input costs and account for private vs. public sector salary differentials.

Results

As shown in Table 1 (page 20), expense per RVU (interpreted as expenses per standardized production unit) is generally higher at teaching clinics. Furthermore, higher teaching clinic costs for nurses' salaries, medical and surgical supplies, administrative expenses, and physician costs are logical because of the additional resources needed to conduct a clinical education program. Similarly, nonteaching clinic costs were higher in the expected areas—promotion and marketing expenditures and outside professional fees. The areas where few differences were found also seem logical. Teaching programs do not affect expenses for telecommunications, laundry, and general medical equipment and instruments.

However, several findings are more difficult to interpret. Surprisingly, teaching programs did not use more radiology procedures. Laboratory utilization rates per RVU and per patient visit were also quite similar, and, where differences occurred, nonteaching clinics showed greater use (see Table 2, above). However, we do not know the volume of episodes of care for which these tests were used and the degree to which they may have varied from clinic to clinic. Nor do we have data that would allow us to explore this possibility further. The high use of clinic drugs and medications (rather than prescriptions) in the teaching clinics may reflect the tendency of those practices to provide pharmaceuticals to Medicaid patients in-house to begin their therapeutic regimen.

Examining staffing levels per RVU was crucial to understanding any differences in support staff salaries. As shown in Table 3 (page 22), teaching clinics employ 70% more FTE registered nurses per RVU produced than do nonteaching clinics. Teaching clinics also employ 10% more licensed practical nurses and medical assistants. When this group is combined with registered nurses, the teaching clinics employ almost twice as many nursing staff per RVU as do nonteaching clinics. This difference explains the 40% higher expense per RVU for nurses' salaries at teaching clinics. These clinics employ more nurses and use a mix of nursing staff that depends more on registered nurses than do nonteaching clinics.

The teaching clinic also used more FTE physicians per RVU. Faculty physicians in teaching clinics spent .27 hours per RVU and .43 hours per patient visit, compared with .24 hours per RVU and .34 hours per patient visit spent by physicians in nonteaching clinics. However, resident physicians added another .72 hours per RVU (or 1.2 hours per patient visit) in the teaching clinics. Obviously, some of the faculty hours were devoted to teaching, but, contrary to expectations, the resident physician contribution to RVUs does not offset these teaching costs.

Teaching clinics employ 20% more FTE medical records support staff per RVU produced than do nonteaching clinics but fewer laboratory staff. Interestingly, the residency clinics in this particular study use 50% more square feet of space per RVU produced than do the nonteaching clinics.

Discussion

The purpose of this project was to assess teaching costs in the ambulatory clinic setting using a production costs approach and to evaluate the availability of the data needed for this type of analysis. Only eight clinics were

Table 3

Teaching versus nonteaching clinic staffing patterns: FTEs per RVU

	Teaching Clinics n=5	Nonteaching Clinics n=3	T/NT
FTE registered nurses	.000053	.000032	1.7
FTE LPNs, medical assistants, etc.	.000155	.000136	1.1
FTE medical records staff	.000063	.000054	1.2
FTE laboratory support staff	.000037	.000064	0.6
Square feet	.341	.229	1.5

included in the study and, consequently, the findings must be viewed with extreme caution.

However, our study found that in most medical group practices, standardized cost and RVU data are readily available from existing (and often computerized) financial records. While some clinics cannot provide detailed cost data in such expense areas as building and maintenance expenses, furniture and equipment, and interest, most can provide sufficiently specific aggregate data in these areas to support comparative cost analyses.

Two areas of our analytic approach need more work. The first relates to accounting for laboratory use. Simply adding up the number of common tests performed without some adjustment for case mix is clearly not a valid way to evaluate these costs. Assigning a shadow price based on the rates charged by community clinics improves the analyses but does not fully resolve the case mix problem.

The second issue involves the method used to account for the contributions of medical residents to the production of RVUs and the portion of their salaries and benefits that should be allocated to those activities. Although the method we propose seems to make sense, it has serious shortcomings. We estimated compensation of teaching clinic faculty using community physician data. This may bias teaching costs upward since faculty often are not compensated at the level of private medical practitioners. The overall cost differences between teaching and nonteaching clinics must, therefore, be viewed with caution.

Given the above caveats, we nevertheless feel that our approach has considerable merit. Our data indicate that, on average, teaching clinics spend $1.62 more for nursing personnel, $1.57 more for in-house medications, and $1.81 more for medical supplies, and that these clinics have $1.27 more administrative costs and $14.70 more physician salary expense per RVU than nonteaching clinics. The increased nursing and physician expenses are largely due to more FTEs per RVU rather than higher salaries per FTE. Teaching clinics used about the same number of faculty physicians per RVU as the total physicians per RVU used by nonteaching clinics. Consequently, most of the resident physician hours are additional costs rather than replacement costs.

This staffing differential carries over to nursing, although the reason isn't clear. Either nurses are also engaged in teaching and so more are needed in these clinics, or the inefficiencies created by teaching affects nurses as well as physicians. Teaching clinics produced an average of 30,844 RVUs per year, while the average RVU production in community nonteaching clinics was 40,552. This difference may have influenced our findings.

We have little information about the economies of scale in these clinics and can't evaluate the effects volume of services has on marginal production costs. If community clinics are operating at a more efficient volume, our teaching cost data are biased upward. Similarly, any other inefficiencies in the teaching clinics will bias our findings toward higher teaching costs. Our study cannot differentiate between legitimate teaching costs and poor management. However, the fact that teaching clinics are successfully competing with similar nonuniversity clinics to provide services on a capitated basis for most of their patients indicates that they are operating with relative efficiency. MM

John Kralewski is professor and head of the Division of Health Services Research and Policy at the University of Minnesota School of Public Health. Kenneth Kephart is assistant professor in the Department of Family Practice and Community Health at the University of Minnesota School of Medicine. Stacy Hakanson is a research assistant in the Division of Health Services Research and Policy at the University of Minnesota School of Public Health.

REFERENCES

1. Boex JR. Defining the cost structure of ambulatory training: a report to the Bureau of Health Professions. Rootstown, OH: Northeastern Ohio Universities College of Medicine, April 1995.
2. Department of Health and Human Services, Health Care Financing Administration. Medicare program: revisions to payment policies and adjustments to the relative value units under the physician fee schedule for calendar year 1994. 58 Fed. Reg. 230 (1993).
3. American Academy of Family Physicians. Facts about family practice 1995: annual facts book. Kansas City, MO: American Academy of Family Physicians, 1995.

MIDWEST INTENSIVE BIOETHICS COURSE (MIBC)
Sheraton Metrodome, Minneapolis, MN
June 22-26, 1997

The MIBC, sponsored by the Bioethics Centers at the University of Minnesota, Medical College of Wisconsin and the University of Wisconsin, Madison, offers an unparalleled opportunity to interact with leaders in the field while developing a strong foundation in bioethics. Comments from prior participants include...

"An excellent review of issues encountered on a regular basis ... Gives one an excellent foundation to help others deal with these problems"

..."excellent presentations as well as breadth of cutting-edge issues."

Participants will: •become familiar with both current and emerging issues in bioethics •gain an understanding of current theories of bioethics and the relative strengths and limitations of these approaches •develop the skill to apply moral reasoning to specific clinical cases •consider personal and organizational ethical challenges in the managed care environment.

Residential ($1200) & non-residential ($950) tuition. CME and CEU's available. Please contact: Center for Bioethics, University of Minnesota, #110, 2221 University Ave SE, Mpls, MN 55414. Phone 612-626-9756/Fax 612-626-9786.

STUTZMAN-HELLING COMPANY
*Your Business & Tax Ally*sm

CONSULTANTS, ACCOUNTING AND TAX ADVISORS
APPRAISALS ARE OUR SPECIALTY
612-546-6375

mayo

Mayo Clinic–Rochester, Department of Otorhinolaryngology, is seeking a board-certified otolaryngologist to do non-surgical practice and offers an excellent salary/benefits package, including malpractice coverage. Relocation assistance provided. For confidential information, please send a current CV to Thomas J. McDonald, M.D., Chair, Department of Otorhinolaryngology, Mayo Clinic, 200 First Street SW, Rochester, Minnesota 55905.

Mayo Foundation is an affirmative action and equal opportunity educator and employer.

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.

3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Joint Pain and Weather

A Critical Review of the Literature

Donald C. Quick, Ph.D.

ABSTRACT

Many people believe that weather conditions can influence joint pain, but science offers no proof. If the phenomenon were real, cause-and-effect mechanisms might provide clues that would aid joint pain treatment. Literature on the subject is sparse, conflicting, and vulnerable to bias, and further physiologic investigations are not likely to produce useful information. However, for patients who believe that weather can influence their pain, the causes may be unknown, but the effect is real.

People often claim that their joints "act up" under changing weather conditions. However, the specific weather parameters they mention—humidity, storms, cold—vary from case to case. Some people with arthritic joints claim that the severity of their symptoms depends on weather conditions, and a subset of these people even claim they can predict weather.[1]

The incidence of arthritic patients claiming weather sensitivity ranges from 34% to 69%, according to various reports.[2-5] This percentage is high enough that virtually every practitioner has encountered patients who make this claim. Physicians frequently list weather-related exacerbations of joint pain in patient records and occasionally describe these pains in medical journal case reports. Even some orthopedic specialists who are themselves arthritic claim to be weather-sensitive.[6,7] Weather-related pain is so commonly reported in primary fibromyalgia that it is listed as a minor criterion for differential diagnosis of that condition.[8]

Because so many people believe that weather can affect joint pain, and because these beliefs have been reported for thousands of years,[9] many assume the phenomenon is real. If so, then their claims should be verifiable by scientific means. However, no conclusive evidence exists that the phenomenon is biologically real or, alternatively, simply an article of folklore. Instead, studies of weather-related pain have inconclusive results and obvious contradictions. Table 1 (page 26) lists 16 studies of weather and joint pain.* Some of these studies found no correlations between pain and weather variables, some found positive correlations, and some found negative correlations. Within one report, some subjects had a positive correlation between humidity and pain while others had a negative correlation.[4] Another study reported similarly contrasting findings for wind speed and pain.[14]

Pain Variables

At least four factors complicate the gathering and reporting of data about human joint pain.

1) Mild or moderate pain in humans can only be measured by asking for a subjective assessment;

2) Individuals have wide ranges of pain thresholds and pain sensitivities;

3) For any one individual, pain sensitivity can change with time, sometimes over a period of minutes; and

4) Perception of pain depends on variables that are difficult to control, such as mood and mental activity.

One way to address variability in pain is to study large numbers of cases so that the discrepancies between individuals will "average out" when the population is considered as a whole. However, many of the studies listed in Table 1 include relatively few subjects.

Weather Variables

Measuring weather variables is much more objective and less complicated than measuring pain. Weather variables include temperature, relative humidity, barometric pressure, wind speed, cloud cover, and precipitation. Nevertheless, many of the studies in Table 1 didn't address subtleties in reporting these variables. For example, weather statistics refer to the macroenvironment, which may

* The 16 studies are listed by reference number, corresponding to the references at the end of the article.

Table 1

Studies of weather and pain

Reference #	3	4	4	5	5	6	9	10	11	12	13	13	13	14	15	16	17	18 [7]	19	20
Disease [1]	RA	OA	OA	OA	RA	RA	RA	RA	FS	RA	FS	OA	RA	FS	pain	RA	RA	RA	RA	RA
Number of Subjects	19	26	37	35	35	12	8	53	32	10	11	24	16	84	340	1	88	13	76	79
Term [2]	1-5 w	1 d	1 d	1 m	1 m	3 w	2 w	1 d	1 m	3 m	1 m	1 m	1 m	1 d	1-3 w	5 y	1 y	3 w	1 y	2 w
Country [3]	Be	US	US	Ca	Ca	US	US	En	Ne	Sw	Is	Is	Is	US	US	Ne	Ne	Ne	En	Ne
Pain correlated with: [4]																				
Barometric Pressure	0	–	+	0	0	0	0	0	0			+	+		–		0	0	0	0
Temperature	–	+	0	0	0	0			0	–	0	+	+	0	0	+	+	0	0	0
Relative Humidity	+	0	+/–	0	0	0	0	0	0	+	0	0	0		+		–	+	+	0
Change in Pressure				0	0	0	– [6]							0	–					0
Change in Temperature				0	0	0									+					0
Change in Humidity				0	0	0	+ [6]									+	+		0	0
Sunshine	+	0	–	0	0				0					0	+		0		0	0
Precipitation [5]	0	0	–	0	0				0		0	+	0	0	–				+	
Wind	0	0	+	0	0	0			0					+/–			0		0	0

[1] **RA**, rheumatoid arthritis; **FS**, fibromyalgia syndrome; **OA**, osteoarthritis; **pain**, non-rheumatoid chronic pain.

[2] **d**, days; **w**, weeks; **m**, months; **y**, years.

[3] **En**, England; **Ne**, Netherlands; **Be**, Belgium; **Sw**, Sweden; **Is**, Israel; **US**, USA; **Ca**, Canada.

[4] **0**, no correlation; +, positive correlation; –, negative correlation; +/–, varied by subject; blank, not tested.

[5] Occurrence, amount or duration.

[6] These effects were observed only in combination, not separately.

[7] This study reported stiffness rather than pain.

be different from the microenvironment of a subject's skin. Virtually all of the data relating to weather and joint pain come from subjects who live indoors, and whose bodies are protected by clothing. When these same subjects venture outdoors occasionally, their hand joints might be exposed directly to the environment, yet only one of the studies was restricted to joints of the hand.[18] Only two of the studies documented the degree of exposure to outdoor conditions, and these reports dealt with patients confined to a hospital during the study.[2,12] One of these studies described rheumatoid arthritis patients whose joint pain correlated with outdoor temperature, although the patients were hospitalized and presumably not exposed to outdoor weather.[3]

Another flaw in many of the studies of weather and joint pain is that researchers only record static conditions—24-hour averages of temperature, relative humidity, barometric pressure, wind speed, cloud cover, and rainfall. Yet individuals' anecdotal claims of weather sensitivity often refer to changes in the weather. Only five of the 16 studies in Table 1 include data on the derivatives of these weather factors. Furthermore, only two studies analyzed weather factors in combination, such as humidity covarying with barometric pressure.[5,9]

Controls

In looking for correlations between episodes of joint pain and weather patterns, researchers should include a wide range of both parameters, which they have not done in the past. With regard to pain, nearly all of the studies published to date have focused on patients with rheumatoid arthritis, osteoarthritis, or fibromyalgia. These syndromes are most commonly reported to include weather-sensitive patients, and the range of pain is fairly comprehensive. With regard to weather, however, two of the studies were conducted over a one- or two-month period, hardly long enough to include the full seasonal range of weather variations.[3,5] Other studies were conducted in places with mildly variant climates, such as the Netherlands (see Table 1).

Most scientific studies include a control population, yet only one of the studies listed in Table 1 had a specific control group.[18] The others were controlled internally to some extent because the statistical methods should be able to distinguish between periods of more pain vs. less pain, and periods of high vs. low values for the weather variables. Investigators might have also assumed (without stating it) that persons with no chronic pathological condition would not experience weather-related pain. Some control subjects should have been included to validate that assumption.

Table 2

Consensus votes regarding weather and joint pain

Group (weighting of votes) [1]	All Studies (by study)			All Studies (by population)			All Studies (by subjects)			Rheumatoid Arthritis (by subjects)			Osteoarthritis (by subjects)			Fibromyalgia Syndrome (by subjects)			Non-Rheumatoid Chronic Pain (by subjects)		
Pain correlations: [2]	0	+	−	0	+	−	0	+	−	0	+	−	0	+	−	0	+	−	0	+	−
Barometric Pressure	**10**	1	1	**11**	4	2	**450**	88	366	**383**	16	0	35	**61**	26	**32**	11	0	0	0	**340**
Temperature	8	4	2	**11**	5	2	**754**	155	29	**215**	105	19	**72**	50	0	**127**	0	0	**340**	0	0
Relative Humidity	8	5	1	**11**	5	1	331	**458**	88	**203**	108	88	**85**	0	0	**43**	0	0	0	**340**	0
Change in Pressure	4	0	2	5	0	2	245	0	**348**	**126**	0	8	**35**	0	0	**84**	0	0	0	0	**340**
Change in Temperature	3	1	0	4	1	0	161	**340**	0	**126**	0	0	**35**	0	0				0	**340**	0
Change in Humidity	4	3	0	5	3	0	**237**	97	0	**202**	97	0	**35**	0	0						
Sunshine	6	2	1	8	2	1	**455**	359	37	**278**	19	0	**61**	0	37	**127**	0	0	0	**340**	0
Precipitation [3]	4	2	2	8	2	2	258	100	**377**	70	**76**	0	**61**	24	37	**127**	0	0	0	0	**340**
Wind	7	1	0	9	1	0	**402**	37	0	**246**	0	0	**61**	0	0	**43**	0	0			

[1] **by study**, each study gets 1 vote; **by population**, each population gets 1 vote; **by subjects**, each population gets 1 vote times the number of subjects.

[2] **0**, no correlation; **+**, positive correlation; **−**, negative correlation; blank, not tested.

[3] Occurrence, amount or duration.

Is There a Consensus?

Despite flaws in the way authors gathered and reported the data listed in Table 1, we can assume that each study attempted to reveal the truth. One way of looking at the table is to consider it a collection of 16 reports, with 20 study populations. If each of the 16 studies is allowed one vote, then the consensus is that none of the weather conditions affected joint pain. If each of the 20 study populations is allowed one vote, the consensus remains unchanged (see Table 2, above).

However, some of those studies included more subjects than others and should perhaps be given proportionately greater weight in determining a consensus. If each subject is given a vote, then relative humidity and change in temperature are positively correlated with joint pain; change in barometric pressure and precipitation are negatively correlated with pain; and the other parameters are not correlated (see Table 2). However, these statistics ignore the fact that 12 of the study populations were rheumatoid arthritis patients, four studies involved osteoarthritis patients, and three studies were of fibromyalgia syndrome patients. One study of chronic pain patients (excluding rheumatoid arthritis and rheumatoid myalgia) dominates the weighted consensus because it involved 340 subjects, while the other study groups ranged from one to 88 subjects. Furthermore, the findings in the nonrheumatoid chronic pain group do not follow the same pattern as the other groups. Therefore, researchers should consider the different disease groups separately.

Table 2 presents separate data for these disease groups. For people with rheumatoid arthritis, only precipitation correlates with pain; that is, rheumatoid arthritics tend to hurt when it rains. For people with osteoarthritis, pain is correlated only with high barometric pressure. High pressure is usually accompanied by clear skies and low humidity, but these specific weather conditions do not appear to affect the pain associated with osteoarthritis. The three studies of people with fibromyalgia syndrome reveal no correlations between weather and pain. The single study of nonrheumatoid chronic pain indicates that pain is positively correlated with a rising temperature, relative humidity, and sunshine; negatively correlated with barometric pressure, falling pressure, and precipitation; and not correlated with temperature value. Thus, nonrheumatoid chronic pain gets worse when the temperature is rising, humidity is high, the sun shines, barometric pressure is low and falling, and there is no rain.

Data Reliability

In the literature reviewed, the most pervasive error in study design (other than small sample sizes) was failure to keep the subjects uninformed about weather reports. We can presume that the subjects read newspapers, listened to the radio, or watched television, and so learned of the current weather conditions and forecasts. This information could unconsciously have biased their propensity to report pain. Subjects in three studies were not told that weather was one of the variables being studied, which helps to reduce the subjective bias in pain reporting, but by no means eliminates it.[5,11,17]

Only the Hollander studies removed the influence of weather forecasts.[6,9,21] Subjects were isolated in a

chamber where researchers could control climatic variables independent of outside weather conditions. In the initial controlled-climate study, none of the atmospheric variables was correlated with joint pain.[6] However, a later study showed that pain correlated with concurrently rising humidity and falling barometric pressure.[9] Despite the fact that this 30-year-old study was among the most rigidly controlled and produced a positive result, subsequent research has not confirmed combined effects of humidity and barometric pressure. Only one other study has analyzed combined weather factors.[3] Results indicated that some rheumatoid arthritis patients were sensitive to a "weather index" calculated from sunshine, precipitation, temperature, and wind velocity.

Hypotheses

Those who profess that weather can affect joint pain face a burden of doubt on two points. First, studies have yet to prove a real relationship exists. Second, researchers have offered no persuasive hypotheses to explain how atmospheric variables may produce pain in the joints.

Humidity alone should not affect subcutaneous tissues directly. Low humidity might dry the skin, perhaps increasing mechanical stiffness of the joint complex, which would, in turn, enhance responses from mechanosensory pain receptors. Humidity might also influence the transfer of heat into or out of the skin, as would rain, wind, or sunshine.

Barometric pressure could have a direct effect on a compressible object, such as an air bladder, but joints do not have gas bubbles. No other joint components would react to the meteorologic pressure changes, which are relatively small.

Atmospheric temperature could warm or cool the joints and directly stimulate temperature-sensitive pain receptors. But temperature also has a number of relevant indirect effects. Elevated temperatures make capillaries less permeable in normal subjects, but the effect is reversed in patients with rheumatoid arthritis.[22] These changes in capillary permeability may, in turn, affect the concentrations of circulating factors that hinder or facilitate the activation of pain receptors.[23] The effect may well be related to abnormalities in local thermoregulation that Edström et al. describe in people with rheumatoid arthritis.[12] Another indirect effect is that low temperatures may increase the viscosity of synovial fluid, thereby making joints stiffer and perhaps more sensitive to the pain of mechanical stresses.[24]

One of the strongest hypotheses is that weather conditions affect the sensation of joint pain through central nervous system pathways. Thus, psychological factors may mediate the effect.[1,15] It is well known that people feel better when the sky is clear, the air is dry and calm, and the temperature is moderately warm; conversely, mood may deteriorate when the weather turns cold, cloudy, windy, or wet. Poor mood might increase subjective complaints of pain. This effect could be reinforced in patients with rheumatoid arthritis who tend to blame their symptoms on something they can understand but cannot control, like the weather.[2] In addition, since heat is an effective therapy for pain and stiffness in rheumatoid arthritis, patients might mentally associate this effect with warm weather, further reinforcing the attribution of weather effects. Similarly, a patient might associate morning stiffness with the cooler, damper weather that occurs at that time of the day.

Conclusion

Many people believe that weather conditions can affect joint pain, but science has neither proven nor disproved this belief. The few studies that exist have uncontrolled biases and are, therefore, not very reliable. One study did find an association between joint pain and simultaneously falling barometer and rising humidity.[9] However, even those results have not been confirmed.

My own interpretation of the literature is that weather-related joint pain is a psychological, not physiologic, phenomenon. Further physiologic investigations are not likely to produce useful information on the topic. However, for patients who believe that weather can influence their pain, the causes may be unknown, but the effect is real. MM

Donald Quick is director of clinical research at the Minneapolis Sports Medicine Center.

REFERENCES

1. Jamison RN, Anderson KO, Slater MA. Weather changes and pain: perceived influence of local climate on pain complaint in chronic pain patients. Pain 1995;61: 309-15.
2. Affleck G, Pfeiffer C, Tennen H, Fifield J. Attributional processes in rheumatoid arthritis patients. Arthritis Rheum 1987;30:927-31.
3. Dequeker J, Wuestenraed L. The effect of biometeorological factors on Ritchie articular index and pain in rheumatoid arthritis. Scand J Rheumatol 1986;15: 280-4.
4. Laborde JM, Dando WA, Powers MJ. Influence of weather on osteoarthritics. Soc Sci Med 1986;23:549-54.
5. Sibley JT. Weather and arthritis symptoms. J Rheumatol 1985;12:707-10.
6. Hollander JL. The controlled-climate chamber for study of the effects of meteorological changes on human diseases. Trans N Y Acad Sci 1961;24:167-72.
7. Patberg WR. Effect of weather on daily pain score in rheumatoid arthritis [letter]. Lancet 1987;(ii):386-7.
8. Yunus M, Masi AT, Calabro JJ, Miller KA, Feigenbaum SL. Primary fibromyalgia (fibrositis): clinical study of 50 patients with matched normal controls. Semin Arthritis Rheum 1981;11:151-71.
9. Hollander JL, Yeostros SJ. The effect of simultaneous variations of humidity and barometric pressure on arthritis. Bull Am Meteorol Soc 1963;44:489-94.
10. Clarke AM, Nicholl J. Does the weather affect the osteoarthritic patient [letter]? Br J Rheumatol 1991;30:477.
11. de Blécourt ACE, Knipping AA, de Voogd N, van Rijswijk MH. Weather conditions and complaints in fibromyalgia. J Rheumatol 1993;20:1932-4.
12. Edström G, Lundin G, Wramner T. Investigations into the effect of hot, dry microclimate on peripheral circulation, etc., in arthritic patients. Ann Rheum Dis 1948;7:76-82.
13. Guedj D, Weinberger A. Effect of weather conditions on rheumatic patients. Ann Rheum Dis 1990;49:158-9.
14. Hagglund KJ, Deuser WE, Buckelew SP, Hewett J, Kay DR. Weather, beliefs about weather, and disease severity among patients with fibromyalgia. Arthritis Care

HealthEast Capitol Medical Laboratory

The Solution to Your Reference Laboratory Needs

Locally owned and operated

Accurate cost-effective testing
24 hours a day, 7 days a week

Technical consultant services

Continuing education seminars

Providing services to:

• physician office laboratories •

• long-term care facilities •

• group home •

• home health care agencies •

For more information, contact

CML Marketing at
(612) 232-3246

HealthEast Capitol Medical Laboratory
69 West Exchange Street
St. Paul, MN 55102-1004
Customer Service: (612) 232-3500

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Internal Medicine
Occupational Health

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES

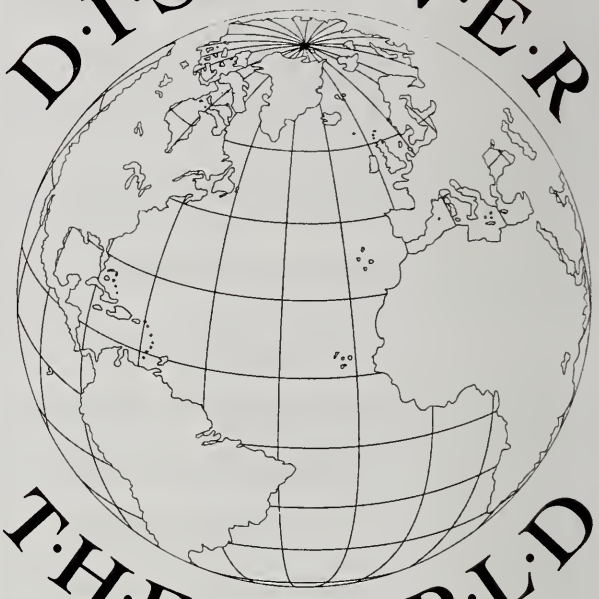
Res 1994;7:130-5.
15. Jamison RN, Parris WCV. Weather patterns affect chronic pain: myth or reality? [abstract]. Pain 1990;5 (Suppl):292S.
16. Patberg WR. Effect of temperature and humidity on daily pain score in a patient with rheumatoid arthritis [letter]. Arthritis Rheum 1989;32:1627-9.
17. Patberg WR, Nienhuis RLF, Veringa F. Relation between meteorological factors and pain in rheumatoid arthritis in a marine climate. J Rheumatol 1985;12:711-5.
18. Rasker JJ, Peters HJG, Boon KL. Influence of weather on stiffness and force in patients with rheumatoid arthritis. Scand J Rheumatol 1986;15:27-36.
19. Rose MB. Effects of weather on rheumatism. Physiotherapy 1974;60: 306-9.
20. Van de Laar MAFJ, Bernelot Moens HJ, van der Stadt RJ, van der Korst JK. Assessment of inflammatory joint activity in rheumatoid arthritis and changes in atmospheric conditions. Clin Rheumatol 1991;10:426-33.
21. Hollander JL. Whether weather affects arthritis [editorial]. J Rheumatol 1985; 12:655-6.
22. Potter JL, Duthie JJR. Effects of environmental temperature upon capillary resistance in patients with rheumatoid arthritis and other individuals. Ann Rheum Dis 1961;20:144-8.
23. Golde B. New clues into the etiology of osteoporosis: the effects of prostaglandins (E2 and F2 alpha) on bone. Med Hypotheses 1992;38:125-31.
24. Tromp SW. Medical biometeorology. New York: Elsevier, 1963:555.

Congratulations
to the New MAPA 1997 Officers

	Work Phone
President	
Lisa Howe	320.240.3157 612.330.1364
President Elect	
Cindy Ulshafer	612.481.0818
Past President	
John Hardman	320.251.8181
Secretary	
Charlene Coplan	612.356.7602
Treasurer	
Ron Johnson	218.354.2111
Government Affairs Chair	
Bev Kimball	612.421.7070
CME Chair	
Slava White	507.387.8231
Membership Chair	
Paula Rooney	612.588.0758
Elections Chair	
Louise Curnow	218.226.4431
Bylaws Chair	
Cindy Lundgren	612.241.0373
Public Education Chair	
Terry Lewis	612.330.1284
Directors-at-Large	
Brenda Bullerman 96-7	507.483.2668
David Cushman 96-7	612.445.6440
Jill Norman 97-8	612.982.5606
Paula Rooney 97-8	see Membership
AAPA Delegates	
Cindy Ulshafer 96-7	see President Elect
Martha Kelly 97-8	612.330.1700
Jeanne Szarzynski 97-8	612.588.0575
Impaired Professionals Liaison	
Karl Nigbor	612.689.1411
Reimbursement Liaison	
Jennifer Dean Dwyer	218.722.8364
Newsletter Editor	
Walt Rothwell	507.281.4924
Job Listing Coordinator	
Paula Rooney	see Membership
Corporate Affairs Liaison	
Carroll Poppen	507.284.3578
Scholarship Committee Chair	
Jill Norman	see Directors-at-Large

Health Volunteers Overseas

D·I·S·C·O·V·E·R



T·H·E· W·O·R·L·D

Health Volunteers Overseas is dedicated to improving the availability and quality of health care in developing countries through training and education. *Volunteer your skills! Become a member of Health Volunteers Overseas!*

For more information, call 202-296-0928



SPECIALIZE IN AIR FORCE MEDICINE.

ER Physicians. Radiologists. OB/GYNs and other specialists! Today's Air Force gives you the freedom to specialize without the financial overhead of running a private practice. Talk to an Air Force medical program manager about the tremendous benefits of becoming an Air Force medical officer:

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay each year

Examine your future in the Air Force. Learn if you qualify. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

FREE Price Comparison to Prove You Can...

SAVE UP TO 70%

on life insurance

Comparing Over 300 Term Plans

Simply complete the request form and we will fax and mail 5 of the top companies for yo

No Obligation...NO Agent Will Visit You...

Choose from A.M. Best Companies rated A thru A++ (Excellent to Superior)
Be Assured You are Getting The Best

MONTHLY PREMIUMS FOR FACE AMOUNT EXAMPLES

Age	$100,000	$250,000	$500,000	$1 Million
30	$10.88	$19.36	$33.50	$57.42
40	$13.05	$24.80	$44.37	$77.43
50	$22.62	$48.72	$92.22	$165.30
60	$46.98	$109.62	$214.02	$389.76
70	$153.12	$374.97	$744.72	$1365.90

Rates are representative of those offered by several different companies and illustrate only the initial guarantee rate of five years. Rates after five years will increase. Rates are based on male, preferred non-smoker rates and monthly bank draft premiums. Female rates may be lower. Company pays for required medical examination. Not available in all states.

To order your Personalized Quote: Fax or mail the request form below
CALL:(800) 552-7283 (SAVE) FAX: (800) 977-1966

YES! Rush me, without obligation, my **FREE** ConsumerQuote USA price quote:

☐ Mail It ☐ Fax It

Name:_____ Sex: M F
Adress: _____
City/State/Zip:_____
Phone: ( ) _____ Fax: ( ) _____
Best time to call: _____
Date of Birth: _____ Tobacco User: YES N
Amount of Coverage:_____ (50,000 Min.)
Initial Guarantee Rate Period: 5 10 15 20 years
Are you currently taking any medications? If yes, name and amounts
_____

Also send a Quote for:
Name: _____ Sex: M F
Date of Birth: _____ Tobacco User: YES N
Amount of Coverage:_____ (50,000 Min.)
Initial Guarantee Rate Period: 5 10 15 20 years
Are you currently taking any medications? If yes, name and amounts
_____

ConsumerQuote USA
5353 Wayzata Blvd. #310
Minneapolis, MN 55416
800-552-7283 (SAVE)

B97-002 (2/97)

MMA Bills to Reduce 2 Percent Tax Are Introduced

The MMA-sponsored bills to begin to phase out the 2 percent provider tax were introduced in the Minnesota House and Senate on January 30 by an impressive list of 19 Senate sponsors and 21 House sponsors. The proposal, S.F. 232 and H.F. 316, would reduce the 2 percent tax to 1 percent for all non-hospital providers beginning July 1, 1997. The chief authors are Sen. Sam Solon, DFL-Duluth, chair of the Senate Commerce Committee, and Rep. Thomas Huntley, DFL-Duluth.

Among the influential legislators who have signed on as cosponsors are Sen. Don Samuelson, DFL-Brainerd, chair of the Senate Health and Family Security Finance Division; Sen. Sheila Kiscaden, R-Minneapolis, lead Republican on the Health and Family Security Finance Division; Sen. Dean Johnson, R-Willmar, Senate minority leader; Rep. John Dorn, DFL-Mankato, chair of the House Health and Human Services Committee; Rep. Dee Long, DFL-Minneapolis, chair of the House Tax Committee; Rep. Steve Sviggum, R-Kenyon, House minority leader; and Rep. Eileen Tompkins, R-Apple Valley, lead Republican on the House Health and Human Services Committee. Because House and Senate rules limit the number of authors on any bill to five, the MMA drafted and introduced five identical copies of the bill. See the sidebar for a current list of sponsors of the MMA bill.

"This strong showing of support is encouraging, but it does not mean that reducing this tax will be easy," said David Renner, MMA director of policy and legislation. "Some key legislators and the governor continue to oppose our efforts."

The MMA proposals have not yet received a hearing. The House and Senate health care committees are concentrating on welfare reform legislation. To qualify for federal welfare block grants, the Legislature must approve a welfare plan by March 31.

Committee Deadlines Are Announced

The Legislature has set 1997 committee deadlines. All bills must have passed out of all policy committees in their house of origin by March 26. All bills, other than appropriations bills, must have passed out of all policy committees in both the House and Senate by April 9. All appropriations bills must have passed out of policy and finance committees by April 18. The Minnesota Constitution requires the Legislature to adjourn no later than May 19, 1997.

Keep Track of Health Care Bills

For information about health care legislation, call House information at 612/296-2146 or 800/657-3550, or Senate information at 612/296-0504 or 888/234-1112. It is helpful to know the bill number.

Locate information on-line at www.leg.state.mn.us.

Announcements

MMA Thanks Cosponsors

The MMA extends its thanks to the following legislators who are cosponsors of the MMA bills to reduce the 2 percent tax.

Representatives

Thomas Huntley, DFL-Duluth, chief author
Fran Bradley, R-Rochester
Sherry Broecker, R-Vadnais Heights
Gregory Davids, R-Preston
Mike Delmont, DFL-Delmont
John Dorn, DFL-Mankato
Kevin Goodno, R-Moorhead
Loren Jennings, DFL-Harris
Jim Knoblach, R-St. Cloud
Dee Long, DFL-Minneapolis
Betty McCollum, DFL-North St. Paul
Richard Mulder, M.D., R-Ivanhoe
Tom Ostoff, DFL-St. Paul
Ken Otremba, DFL-Long Prairie
Michelle Rifenberg, R-La Crescent
Doug Stang, R-Cold Spring
Steven Sviggum, R-Kenyon
Howard Swenson, R-Nicollet
David Tomassoni, DFL-Chisholm
Eileen Tompkins, R-Apple Valley
Todd Van Dellen, R-Plymouth
Charlie Weaver, R-Anoka
Robert Westfall, R-Rothsay

Senators

Sam Solon, DFL-Duluth, chief author
Don Betzold, DFL-Fridley
Jerry Janezich, DFL-Chisholm
Dave Johnson, DFL-Bloomington
Dean Johnson, R-Willmar
Sheila Kiscaden, R-Rochester
David Knutson, R-St. Cloud
James Metzen, DFL-South St. Paul
Edward Oliver, DFL-Deephaven
Leonard Price, DFL-Woodbury
Martha Robertson, R-Minnetonka
Linda Runbeck, R-Circle Pines
Don Samuelson, DFL-Brainerd
Dan Stevens, R-Mora
LeRoy Stumpf, DFL-Thief River Falls
Roy Terwilliger, R-Edina
Jim Vickerman, DFL-Tracy
Chuck Wiger, DFL-North St. Paul



Viewpoint

Raymond G. Christensen, M.D.
President, Minnesota Medical Association

Public Health Is High on MMA Legislative Agenda

The Minnesota Medical Association takes pride in its mission to promote public health. This session, the MMA is pursuing legislation to make it harder for adolescents to buy tobacco, to reduce the number of alcohol-related accidents, and to increase seat belt use.

The MMA enables us to expand our role as patients' advocates. In our practices, we ask our patients whether they smoke and, if they do, we encourage them to quit. Through our membership in the MMA, we support legislation aimed at reducing the number of smokers statewide. Working together, we physicians have enough influence to pass legislation that promotes a healthier environment. This session, the MMA, working with the Smoke-Free 2000 Coalition, is supporting a bill to prevent teenagers from buying tobacco. The bill would require retail outlets that sell tobacco to be licensed and would set fines for the license holder and for anyone who sells tobacco to a person under age 18. Local communities would keep their present power to pass more restrictive penalties.

Some retailers have joined the powerful tobacco industry to fight this bill. In my opinion, public health benefits outweigh any inconvenience to retailers. Rep. Ann Rest, DFL-New Hope, cited chilling statistics when she introduced the bill. Every day 60 Minnesota children smoke their first cigarette. Half of them are under 14. By the time they reach high school, 70 percent of these youngsters will want to quit smoking but can't because they're addicted. Eventually, 20 of them—one out of three—will die of tobacco-related causes. We need strong legislation to prevent these kids from getting hooked on nicotine. No one questions the responsibility of liquor store owners and clerks to determine a buyer's age before selling liquor. Tobacco retailers should have the same responsibility.

The MMA is supporting a bill drafted by Mothers Against Drunk Drivers (MADD) to lower the blood alcohol level needed for a driving while intoxicated (DWI) conviction from .1 percent to .08 percent for adults and to .04 for those under age 21. MADD predicts this bill could save about 40 lives in Minnesota each year. According to the National Highway Traffic Safety Administration, at .08 percent blood alcohol level, a driver has impaired accuracy of steering, braking, speed control, lane tracking, gear changing, and judgment of speed and distance. A driver's ability to respond to emergencies is impaired at .04 percent.

The change in the DWI law would apply to drivers of snowmobiles, all-terrain vehicles, and motorboats, as well as motor vehicles. My personal awareness of the need for such legislation was heightened during the winter of 1996-97 when, as medical director for Pine County, I signed death certificates for six of Minnesota's 25 snowmobile deaths. The mix of alcohol with young, inexperienced, or inattentive drivers, rites of passage, and powerful snowmobiles capable of going more than 100 miles per hour are a deadly combination. Recreational vehicles with the same power and speed as cars are traveling along unimproved country roads, often with fatal results.

The MMA is also urging lawmakers to pass a bill that would allow police officers to stop and ticket motorists who are not wearing seat belts. Other states have found that seat belt use goes up 15 percent when such a law is passed. Currently, Minnesota law requires the use of seat belts, but violators can only be ticketed if they have been stopped for another offense. The need for a stronger seat belt law is greater now that airbags are standard features in automobiles. Airbags are designed to be used with seat belts. Without a seat belt, the airbag that can save a life can cause injury or even death. Seat belts keep drivers and passengers from flying forward into airbags that inflate at speeds up to 200 mph. Together, airbags and seat belts prevent deaths and injuries and save money.

Last year, the MMA succeeded in passing legislation to strengthen the law requiring safe storage of firearms in homes with children. This law was a step forward, but accidental deaths and impulsive homicides continue. Some physicians ask their patients if they lock up their firearms. Others display the MMA firearm safety brochure in their clinic.

I have mentioned just a few of the MMA's public health initiatives. The MMA has long sought legislation to require motorcyclists and bicyclists to wear helmets. Our award-winning campaigns against domestic violence and media violence continue. Our list of public health concerns continues to grow.

Through your membership in the MMA, you are working for a healthier Minnesota.

PUBLIC HEALTH LEGISLATION

Smoke-Free Bill Passes House

The Minnesota House of Representatives unanimously passed the Smoke-Free 2000 bill to license stores that sell tobacco. Before passing the bill, the House weakened it by deleting a provision that required "stings" or compliance checks and by changing the outright ban on cigarette vending machines to allow machines that are in sight of a clerk. The House Commerce Committee earlier had removed a provision to ban slotting fees—the practice of paying a retailer to place tobacco products in a particular place.

As amended the bill, H.F. 117, introduced by Reps. Anne Rest, DFL-New Hope, and Kevin Goodno, R-Moorhead, would:

- require retail outlets that sell tobacco to be licensed;
- set fines for the license holder and the person who sells tobacco to anyone under age 18;
- ban tobacco sales from vending machines that are out of sight of a clerk in any establishment open to young people under age 18; and
- allow local communities to keep their present power to pass more restrictive penalties.

Rest and Goodno presented the bill to the House Commerce Committee in a hearing room packed with antismoking advocates, many of them children. Testifying on behalf of the Smoke-Free 2000 Coalition, eleven-year-old Shawn Rowley told the committee, "It's easy for kids to buy cigarettes." Rowley was speaking from experience. He went with his teenage sisters to test compliance with the current law against selling tobacco to minors. His sisters had no trouble buying cigarettes. Then they urged Shawn to try. "I went into a restaurant, made eye contact with the waitress and put my money in the vending machine. I dropped my quarter so I had to go back to the car and get more money. I came back in, made eye contact with the waitress again, and finished buying a pack of cigarettes. Nobody tried to stop me."

Rest told the committee that 100 organizations, including the MMA, support the bill. "If we want the law to work, we have to bring the stores that sell tobacco into the circle of accountability," Rest said.

The Senate companion bill, S.F. 232-Junge, is expected to receive a committee hearing soon.

Child Safety Belt Bill Fails

A bill to strengthen seat belt laws for young people, H.F. 221-Rhodes, passed the House Transportation and Transit Committee but failed on the House floor by an 80-48 vote. This bill would have required children between 3 and 17 years old to wear a seat belt and would have allowed law enforcement officials to ticket drivers if the children were not wearing seat belts. For the first time, failure to wear a seat belt would have been a primary offense. Currently, officers may only issue a citation if they have stopped the driver for another violation.

The MMA strongly supports tougher seat belt laws. An MMA-supported bill to make failure to wear a seat belt a primary offense for adults as well as children, S.F. 170-Dille, has been introduced and is waiting to be heard in the Transportation Committee. There is no companion bill in the House.

Change in Drunk Driving Law Moves Forward

The MMA-supported Mothers Against Drunk Drivers (MADD) bill, S.F. 77-Marty, to raise the blood alcohol level that constitutes driving under the influence of alcohol from .1 percent to .08 percent easily passed the Senate Crime Prevention Committee. The MMA distributed a letter of support from MMA President Raymond Christensen, M.D., to committee members, urging them to pass this important public safety bill. "Your proposal has the potential to curb total alcohol consumption, which would not only save lives on Minnesota's roads, but also reduce total mortality and morbidity related to alcohol," wrote Christensen. He noted that there was a significant number of deaths caused by stroke, suicide, cancer, and falls that were directly attributable to alcohol in addition to the deaths that occurred because of alcohol-related motor vehicle crashes.

MADD's proposal would also lower to .04 percent the minimum level needed for a DWI conviction for people under age 21. Since August 1, 1996, underage drivers have been subject to a zero tolerance law that makes it a misdemeanor offense to drive with any alcohol in the bloodstream. According to MADD, approximately 40 lives a year would be saved if the legal limit was reduced to .08 percent.

Thirteen states have a .08 percent standard while the rest, including Minnesota, have the .1 percent standard.

The House companion bill, H.F. 62-Swenson, is waiting to be heard by the Judiciary Committee.

Firearm Safety Brochure Is Available

The MMA brochure, "Unload It and Lock It," tells how to safely store and use firearms. To obtain brochures for your patients, call Beth Hoheisel at 612/378-1875 or 800/DIAL-MMA (800/342-5662).

MINNESOTA NEWS

Governor's Plan Gets Little Support

Gov. Arne Carlson's proposal to eliminate the General Assistance Medical Care (GAMC) program and move its enrollees into MinnesotaCare is receiving little support from legislators and is presumed to be on its deathbed. The MMA, along with other provider organizations, sent a letter to the governor and to the chairs of the key health care committees, expressing strong opposition to using the 2 percent provider tax to pay for the GAMC program. "We believe that the transfer proposal breaks the agreement made with the state's health care providers that established the provider tax exclusively for funding the MinnesotaCare program. ... Not only does this proposal represent bad budget policy, but it represents a major departure from the original purpose of the Health Care Access Fund." The letter was signed by eight provider groups in addition to the MMA.

"Although the governor's proposal is going nowhere this session, we are using it as an example of what we have feared since the 2 percent tax was first adopted," said David Renner, MMA director of policy and legislation. "We have said all along that, as long as the provider tax existed, it would be too easy for policymakers to use it to pay for more and more state programs." The MMA is determined to prevent the use of the 2 percent tax for any purpose other than MinnesotaCare.

• • • • • • •

HCFA Approves MA Surcharge

The governor withdrew another controversial proposal in his budget, which would have eliminated the 1.5 percent surcharge on hospital revenues and replaced this money with an increase in the hospital provider tax from 2 percent to 3.88 percent. The Minnesota Medical Association and other groups strongly opposed the governor's proposal.

Carlson backed off on this proposal after the Health Care Financing Administration ruled that the state's 1.5 percent surcharge on hospital revenues, which is used to fund the Medical Assistance program, does qualify for federal matching funds. This is surprising news since HCFA previously indicated that the surcharge did not meet the statistical test to be considered a broad-based tax.

• • • • • • •

Repeal of $400 Surcharge Is Introduced

The MMA strongly supports the bill, H.F. 511-Otremba, which calls for repeal of the $400 surcharge on physicians' medical licenses. This bill also includes the Minnesota Hospital and Healthcare Partnership's rural health initiatives, which would designate a sole community hospital as an essential community provider; ensure rural representation on the Minnesota Health Care Commission; establish a demonstration project for rural hospital consolidation and cooperation; and establish a grant and loan program to rural hospitals for capital improvements.

March is MMA Meet With Your Legislator Month

• • • • • The MMA is offering a new grassroots program during the 1997 Legislative session—MMA Meet With Your Legislator Month. The MMA will arrange a meeting for you with your legislator any Tuesday or Thursday morning in March. MMA legislative staff will meet you at the House cafeteria, brief you on current health care legislative issues, and escort you to your legislator's office and/or to a Senate or House health care committee meeting. Appointments are scheduled two to three weeks in advance.

Personal contact with your legislator is especially important this session. The MMA will need strong grassroots support from its members to pass the MMA bill calling for a reduction of the 2 percent provider bill. Many legislators are very supportive, but this will be an uphill battle. If your legislator is one of the 19 senators or 24 representatives who have signed on as a sponsor of the MMA bill, you may wish to extend your thanks.

If you live in a district that has a new legislator, a March meeting offers you a good opportunity to introduce yourself and offer your assistance on health care issues. Legislators are glad to have physician constituents they can rely on for advice on health care issues.

If you have any questions, call Wendy O'Donnell or David Renner at 612/378-1875 or 800/DIAL-MMA (800/342-5662).

MINNESOTA NEWS

Repeal of Growth Limit Introduced

The Minnesota Department of Health has drafted a bill to replace Minnesota's growth limits with "cost containment goals." Repeal of the growth limits is one of the MMA's top priorities this session. The MMA is reviewing the language of this proposal. The bill, S.F. 246-Kiscaden/H.F. 34-Haas, has not yet received a hearing.

• • • • • • •

MMA Bill Would Limit Use of "Physician"

Sen. Don Betzold, DFL-Fridley, and Rep. Lee Greenfield, DFL-Minneapolis, have introduced an MMA-drafted bill, S.F. 176/H.F. 498, to forbid all providers except medical doctors and doctors of osteopathy to describe themselves as "physicians." All other providers would have to refrain from using the designation "physician" either alone, or in conjunction with another term, except for podiatrists, who could describe themselves as "podiatric physicians."

• • • • • • •

ACOG's Direct Access Bill Moves Forward

The Minnesota Section of the American College of Obstetricians and Gynecologists (ACOG) bill, S.F. 389-Wiener/H.F. 447-Murphy, has passed out of committees and is awaiting action on the House and Senate floors. This bill would require Minnesota health plan companies to allow women to have direct access to obstetricians and gynecologists for annual preventive health examinations, maternity care, and treatment for acute gynecologic conditions or emergencies. Women would not have to obtain referrals or prior approval, and health plans would not be allowed to charge higher copayments, coinsurance, or deductibles.

This is consistent with MMA policy. The 1995 MMA House of Delegates passed a resolution supporting the preservation of a woman's ability to directly access preventive health, diagnostic, and treatment services provided by ob/gyns.

State Growth Limit Is Higher Than Expected

• • • • • The 1997 growth limit on health care spending is 6.5 percent for providers who comply with the law through limits on growth of their revenues per patient or revenues per encounter. The 6.5 percent growth limit reflects the 1996 regional consumer price index for urban consumers of 3.1 percent plus the 3.4 percent X factor set by law to reflect increases in volume and intensity. This is slightly higher than the projected growth limit of 6.4 percent. Providers who comply with the law through a limit on increases in their fee schedule are subject to a growth limit of 3.1 percent, the CPI-U.

RWJ Grant Aims to Reduce Underage Drinking

The Robert Wood Johnson Foundation and the American Medical Association have awarded Minnesota $840,000 to implement policies and practices to reduce underage drinking. Minnesota is one of 11 states that received funding. The Minnesota Institute of Public Health, a nonprofit organization that has provided public health direction and services throughout the state for 25 years, will manage the grant.

The Minnesota Join Together Coalition to Reduce Underage Alcohol Use, a statewide coalition of organizations (including the Minnesota Medical Association) that is working to reduce underage drinking, announced its acceptance of the grant at a news conference in St. Paul on January 21. The coalition will collaborate with at least 30 organizations throughout the state to achieve the following goals: maintain local control of the distribution and sale of alcohol, enable local community agencies without law enforcement responsibilities to conduct regular compliance checks of retail alcohol outlets, strengthen local policies governing alcohol use at community events, require beer keg registration, expand liability of social hosts, and implement server/manager training.

The MMA sent a letter to RWJ and the AMA expressing its commitment to this project, and Mark Vukelich, MMA director of communications, testified on its behalf.

• • • • •

MINNESOTA NEWS

Bill to License Naturopaths Is Introduced

Three Minneapolis DFLers, Rep. Linda Wejcman, Rep. Karen Clark, and Sen. Linda Berglin, have introduced a bill, H.F. 396/S.F. 523, that would give the Minnesota Board of Medical Practice authority to license naturopaths who have graduated from an approved naturopathic medical college and passed the licensing examinations. This controversial bill would allow naturopaths to describe themselves as "naturopathic physicians" and would allow them to conduct laceration repair and small lesion removal, perform various diagnostic tests, including phlebotomy, electrocardiogram, and x-ray, and perform naturopathic home childbirth.

The bill would probably affect no more than 15 naturopaths in Minnesota, including naturopathic practitioner Helen Healey, who operates Wellspring Naturopathic Clinic in St. Paul. Healey's patients and supporters rallied around her last year when the Minnesota Board of Medical Practice charged that she was practicing medicine without a license. The dispute was settled out of court.

Healey is leading the effort to seek licensure because she is concerned that people who are not qualified are calling themselves naturopaths. The bill would limit the practice of naturopathy to those who have been trained by one of three accredited schools of naturopathy in the United States, which offer four-year graduate level programs. Currently, 11 states license naturopaths.

It remains to be seen whether the health care committees will be willing to take up such a controversial bill this session when so much time must be devoted to passing welfare legislation.

State Passes Frog Problem on to Federal Agencies

The Minnesota Pollution Control Agency (MPCA) will not seek further legislative funding to investigate why frog deformities are popping up in Minnesota and is seeking the help of federal agencies, which the MPCA believes are better equipped to do basic research. Speculation on why there has been an increase in frog deformities has pointed to such possible causes as parasites, air pollution, synthetic chemicals such as pesticides and herbicides, and climatic changes that affect rainfall. The 1996 MMA House of Delegates resolved to support scientific efforts to investigate the causes of anomalies in the frog population and birth defects and to work with other organizations to understand these anomalies and defects, and to "reduce the biologic impact of identifiable etiologic agents."

MMA Sponsors Youth Summit

About 250 high school students came to the state capitol in St. Paul on February 11 to learn about the legislative process at a Youth Summit sponsored by the Minnesota Medical Association, the office of Attorney General Hubert H. Humphrey III, and the University of Minnesota's Center for Community Legal Education at the Center for 4-H Youth Development. The topic of this year's Youth Summit was hate crimes. "Many legislators told me how pleased they are that the MMA is sponsoring the Youth Summit again this year," said Mark Vukelich, MMA director of communications. The MMA designed and sponsored the T-shirt worn by the participants, which said: "Whoever owns this shirt told the state legislature



exactly what they thought of the laws affecting today's youth. If you have the guts to speak your mind, you'll be wearing one next year."

What Is the Appeal of Homeopathy?

Leonard G. Wilson, Ph.D., professor of the history of medicine at the University of Minnesota, explored the origin of homeopathy in the third in a series of lectures on the history of medicine at the University of Minnesota on January 27.

The founder of homeopathy, Christian Friedrich Samuel Hahnemann, born in 1755 in Saxony, developed a theory of medical treatment that encountered ridicule from the time it was first introduced until the present day, and yet homeopathy has persisted. Why? What is its appeal?

According to Wilson, homeopathy may be "curious and fantastic," but it is not ridiculous. "Two centuries of medical science have destroyed all basis for this theory, but it saved many lives. During the epidemics of typhus and scarlet fever in the nineteenth century, homeopathic doctors saved a much higher proportion of their patients than did physicians."

Ironically, homeopathy, which its critics consider the antithesis of science—little more than quackery—grew out of Hahnemann's determination to build his medical practice on a more scientific basis. According to Wilson, Hahnemann was first and foremost a physician, deeply learned in medical literature, a man who kept abreast of advances in clinical medicine throughout his life. Early in his career, he abandoned his medical practice because he was frustrated by the lack of scientific evidence. Hahnemann believed there was no credible theory of treatment—recovery was often spontaneous, and when patients were cured it was unclear how or why. Patients received a mixture of various drugs so it was impossible to pinpoint which one had effected the cure. If medicine was ever to become reliable, Hahnemann believed, it must be based on using a single drug of known effect, which had been tested on a healthy body.

The turning point in Hahnemann's career was his experiment with Peruvian bark, a remedy used to cure intermittent fever. Hahnemann, when healthy, took 4 grams of Peruvian bark twice a day. His fingertips became cold, he felt languid, experienced palpitations, anxiety, trembling, a flushed face, and was intensely thirsty—symptoms of intermittent fever. His symptoms vanished as soon as he stopped taking the bark. Hahnemann deduced from this experiment that like cures like. Minute doses of a drug that causes a disease will cure that disease.

He returned to medical practice and put his new theory to work, preparing and dispensing his own medications. In 1801 he gave a 10-year-old girl who had scarlet fever minute traces of belladonna, and she recovered. When Hahnemann published his theories, he unleashed a torrent of criticism, which may have stimulated sales of his books. In the typhoid epidemic of 1813, Hahnemann was far more successful than traditional physicians who bled and purged their patients, and his practice grew.

Physicians became jealous of his success and apothecaries pursued him in the courts for dispensing medications. Hahnemann argued that he did not mix drugs but only prepared and dispensed simple substances such as camphor, sulfur, and belladonna. He used such minuscule amounts that they could not be detected through chemical analysis and he shook the preparations, which he believed released their potency.

Hahnemann developed other theories. He believed that chronic diseases were caused by a single underlying factor such as Psora, the itch, or by syphilis. Although the external itch could be cured quickly, Hahnemann believed that unfavorable circumstances could arouse the Psora to become active and cause internal disease. He believed that people inherited predispositions to various diseases.

Although he remained a focus of controversy, Hahnemann gradually built a group of devoted followers, some of whom went on to establish schools of homeopathy in the United States. When permission was granted in 1888 to establish a medical school at the University of Minnesota, it was conditional on establishing a homeopathic college of medicine at the same time. The homeopathic school faded out around 1908.

"Hahnemann's great strength was that ordinary medical treatment at that time was so frequently disastrous," Wilson said. Physicians in the nineteenth century were bleeding their patients. Hahnemann believed in the curative power of the human body and he focused intense personal attention on each patient. Today, homeopathy is experiencing a revival, perhaps because of managed care and the complexity of medicine, Wilson suggested.

A physician in the audience noted that a modern homeopathic remedy for sore throat contains traces of belladonna and snake venom, hardly the single simple drug that was at the heart of Hahnemann's theory. "There has been some corruption of Hahnemann's ideas in their transfer to the supermarket," Wilson said.

• • • • •

MMA Has a New Phone Number

• • • • • The MMA's toll free long distance phone number has been changed to 800/DIAL MMA or 800/342-5662.

Visit the MMA Home Page

• • • • • The MMA Web site includes information on MMA legislation and advocacy, news, a staff directory, links to related organizations, discussion groups, CME information, and links to the best clinical resources, products, and services. Visit the MMA home page at: www.mnmed.org

Clinton Proposes Cuts in Medicare Spending Growth

President Clinton has proposed a Medicare budget that would save an estimated $100 billion over five years. Total expenditures for physician services would be held to $7.8 billion less than under current law, according to the American Medical Association (AMA).

Cut Surgeons Fees

Clinton's budget plan would redistribute money from surgery to diagnostic procedures by substituting a single conversion factor for the three that exist today. The AMA predicts that the 1998 conversion factor will be set at $36.63. The 1997 conversion factors are $40.96 for surgery, $35.77 for primary care, and $33.85 for other services. Primary care would receive a normal inflation update in 1998. Surgery's conversion factor would fall by 10.6 percent, and payments for other services would rise by 8.2 percent.

Reduce HMO Geographic Disparities

Clinton proposes to reduce the current geographic disparities in HMO payment rates, remove payments for medical education and indigent care from the HMO rate, and cut HMO payments from 95 percent to 90 percent of the cost for fee-for-service patients in the same area. He also wants to shift at least $62 billion in home health services from Part A to Part B Medicare. The AMA predicts that if Congress rejects either the home health shift or the HMO provisions, it may propose deeper provider cuts than those in Clinton's budget.

Repeal Fraud Provisions

The Clinton administration also wants to repeal the following fraud provisions that were included in last year's insurance reform bill:

- a managed care exception from Medicare and Medicaid anti-kickback statutes;
- a requirement that the government issue advisory opinions on whether a proposed business venture violates the anti-kickback statute; and
- a provision that increased the government's burden of proof in cases involving civil monetary penalties.

The AMA says the fraud provisions are necessary to protect physicians who have made innocent billing errors, but the Clinton administration argues that the provisions interfere with efforts to crack down on deliberate fraud.

• • • • •

Ramstad Proposes Medicare Equity Bill

Minnesota U.S. Rep. Jim Ramstad, R, has introduced legislation, H.R. 554, to reduce the inequities in Medicare reimbursement among the states. Minnesota's payment rates are among the lowest in the nation. The national average for Medicare payments to counties throughout the nation is $467 per month per beneficiary. None of the 87 Minnesota counties receives this much. Ramstad's bill would change the formula so that each Minnesota county would receive at least $373 —80 percent of the national price adjusted capitation rate. Minnesota Reps. Gil Gutnknecht, R, David Minge, DFL, Bruce Vento, DFL, Bill Luther, DFL, and James Oberstar, DFL, are cosponsors of the bill.

"The Geographic Coalition is encouraged by this proposal, and is analyzing its provisions," said Janet Silversmith, MMA health policy analyst. The MMA is a founding member of the Geographic Coalition, which includes 24 medical societies working together for fair Medicare reimbursement.

Helping to draft Ramstad's Medicare legislation were Dave Durenberger, former Republican senator from Minnesota, and his wife and former policy aide Susan Foote, who have started a new lobbying firm focusing on health policy. One of their largest clients is the Fairness in Medicare Coalition, which consists of 35 health care organizations, working to improve equity in Medicare reimbursement. The health plans and hospital systems in the coalition pay $12,000 in annual dues. The Fairness in Medicare Coalition shares some of the same concerns as the Geographic Coalition, and the two organizations have met to discuss effective ways to work together.

• • • • •

AMA Seeks Extension for New Practice Expenses

The American Medical Association (AMA) has announced plans to seek legislation that would give the Health Care Financing Administration (HCFA) a one-year extension to develop practice relative values that reflect the physician's actual practice expenses. The AMA wrote a letter to HCFA expressing concerns about the data and methodology to be used in developing the practice expense relative values.

• • • • •

The Monitor
MARCH 1997
• • •
PRESIDENT
Raymond G. Christensen, M.D.
CHAIR, BOARD OF TRUSTEES
Timothy J. Crimmins, M.D.
CHIEF EXECUTIVE OFFICER
Paul S. Sanders, M.D.
DIRECTOR, COMMUNICATIONS
Mark S. Vukelich
EDITOR
Lorrie Holmgren
• • •



Keep Your Balance.

With the new EquiLink℠ annuity from Great American® Life Insurance Company, your retirement dollars are safeguarded with the traditional features of a tax-deferred[1] fixed annuity while also participating, in part, in any increases of the S&P 500® Index, a widely accepted and broad measure of the performance of the major U.S. stock markets.

So you get both the inflation-beating GROWTH potential normally associated with a stock market index ***and*** the SECURITY of a tax-deferred annuity — an annuity with a money-back guarantee at the end of each term and additional interest on a portion of your principal!

EQUILINK℠

An Annuity with Interest Earnings Linked to the S&P 500® Index!

PHYSICIAN APPROVED MMBR ASSOCIATION ENDORSED

For more information call: **1-800-298-6627**
MMBR Insurance Agency
3433 Broadway St. N.E.
Suite 375
Minneapolis, MN 55413

Underwritten by:

GREAT AMERICAN® LIFE INSURANCE COMPANY
250 East Fifth St.
Cincinnati, OH 45202

[1] Tax laws are subject to varying interpretations and possible changes. Distributions are subject to taxation at time of receipt. Distributions prior to age 59 1/2 are subject to possible tax penalties and, for a TSA policy, significant tax law restrictions. Please consult your agent and tax advisor for further information.

"Standard & Poor's®" and "S&P 500®"are trademarks of The McGraw-Hill Companies, Inc. and have been licensed for use by Great American® Life Insurance Company. EquiLink℠ is not sponsored, endorsed, sold, or promoted by Standard & Poor's, and Standard & Poor's makes no representation regarding the advisability of purchasing this product.

EquiLink℠ is a fixed annuity with interest earnings linked, in part, to the S&P 500® Index. It is not a variable annuity, mutual fund or equity investment.

4173 (1/97)

Concerned about taxes, inflation and retirement?

Now is your opportunity to do something about it!

MMA presents the nationally acclaimed seminar: Innovative Financial Strategies

Saturday, May 10
Radisson South Hotel
Minneapolis
8:30 am to 12 noon

Saturday, Nov. 8
Mariott Airport Hotel
Bloomington
8:30 am to 12 noon

Here's what you'll learn:

- How to overcome common obstacles and achieve your financial goals.
- Developing the right plan to build and protect your retirement nest egg.
- How to avoid the 15% tax penalty on what the government says is "too much" retirement income.
- Techniques that can help you increase returns while reducing risk.
- What you can do right NOW to minimize your estate tax.

"Best course on financial planning available!"
—James Hernandez, M.D.

"Every physician should attend this seminar."
—Lisette Solomon, M.D.

Join over 5,000 physicians who have already benefitted from this seminar. Powerful financial planning techniques will be presented by MMBR. The cost is just $99.00 for MMA members, $119.00 for non-members. Your spouse is invited free of charge. Call today to reserve your place!

800-298-6627

MMBR

Minnesota Medical Business Resources
Owned By MMA & HMS

Impact of the 'Back to Sleep' Campaign on Sudden Infant Death Syndrome in Minnesota

Widespread use of the supine infant sleep position has reduced SIDS incidence in Minnesota and in countries throughout the world.

Patrick L. Carolan, M.D., Kathleen L. Fernbach, B.S.N., R.N.,
Sharyn A. Larson, B.S.N., R.N., and Junie C. Svenson, M.P.H.

Editor's Note: The death of a child is difficult for parents, physicians, and the community. It is even more difficult when the child was healthy and found dead after a nap or a night's sleep. SIDS leaves grief-stricken families and their physicians with many questions and few answers. The Minnesota SID Center can help. They have many informational brochures, support groups, and hot lines for parents, grandparents, and even siblings regarding SIDS. They also offer hope. The "Back to Sleep" campaign is easy to implement in your office and appears to be effective in lowering SIDS deaths. Read the following discussion, and, if you haven't already done so, join the "Back to Sleep" campaign.

—Barbara P. Yawn, M.D., M.Sc.,
Series Editor

Since the earliest epidemiologic studies of sudden infant death syndrome (SIDS), researchers have recognized an association between prone infant sleeping and SIDS. Case-controlled studies emerged from Australia, the United Kingdom, and Europe in the late 1980s and early 1990s suggesting that prone sleeping—with the face down—was a specific SIDS risk factor. Based on these studies, public health officials from around the world launched campaigns that indicated the supine sleep position—with the face up—may reduce an infant's risk for SIDS. The United States "Back to Sleep" campaign in the spring of 1994 embodied the same message.[1] Adopting the supine infant sleep position has reduced SIDS incidence in Minnesota and in countries throughout the world.

SIDS Incidence

State law requires that SIDS deaths that occur in Minnesota must be reported to the Minnesota Sudden Infant Death Center (Minnesota Statutes 390.11 and 144.053). The medical examiner or coroner for the jurisdiction in which the death occurred certifies SIDS diagnoses according to the Minnesota Infant Death Investigation Guidelines or related protocol.[2] A monthly audit conducted by the Minnesota SID Center of death certificates filed with the Minnesota Department of Health verifies the SIDS deaths.

Figure 1 (page 44) depicts SIDS incidence in Minnesota from 1985 to 1994. (Yearly SIDS incidence is determined by dividing total SIDS cases by live births for the year.) During this 10-year period, the state experienced an overall decline in SIDS of 38%.

The table (page 45) reports changes in the incidence of SIDS over different time periods from a sample of SIDS centers in the United States and around the world. We gathered this data from abstracts presented at the Fourth SIDS International Conference, held in Bethesda, Maryland, in June 1996.[3]

Discussion

Campaigns to reduce prone infant sleeping have been quite effective, more so in certain areas overseas than in the United States. In the United Kingdom, Australia, New Zealand, and parts of Scandinavia, campaigns reduced rates of prone sleeping from 40% to 70% precampaign to between 2% and 5% postcampaign. A spring 1995 survey of households in the United States revealed a rate of prone sleeping of 29%, as compared with 70% in 1992.[4] In Minnesota, a spring 1993 survey of infant care practices reported a rate of prone sleeping of 25% for 1-month-olds.[5] A study of pediatric recommendations pertaining to infant sleep practices demonstrated that a majority of practitioners surveyed in Minnesota had incorporated elements of the "Back to Sleep" message into their regular medical visits.[6]

Neuropathology studies suggest that infants with subtle nerve cell abnormalities may be more vulnerable to SIDS.[7-9] These studies describe abnormalities of myelin sequencing, preservation of dendritic spines, and reduced numbers of muscarinic receptors.[10-12] The anatomic regions involved include the brainstem reticular formation of the ventrolateral medulla and forebrain structures within the prefrontal-limbic cortex. These regions play significant roles in cardiorespiratory control, thermoregulation, sleep state regulation, and the integration of arousal responses. ⇨

Figure 1

SIDS Incidence in Minnesota, 1985-1994

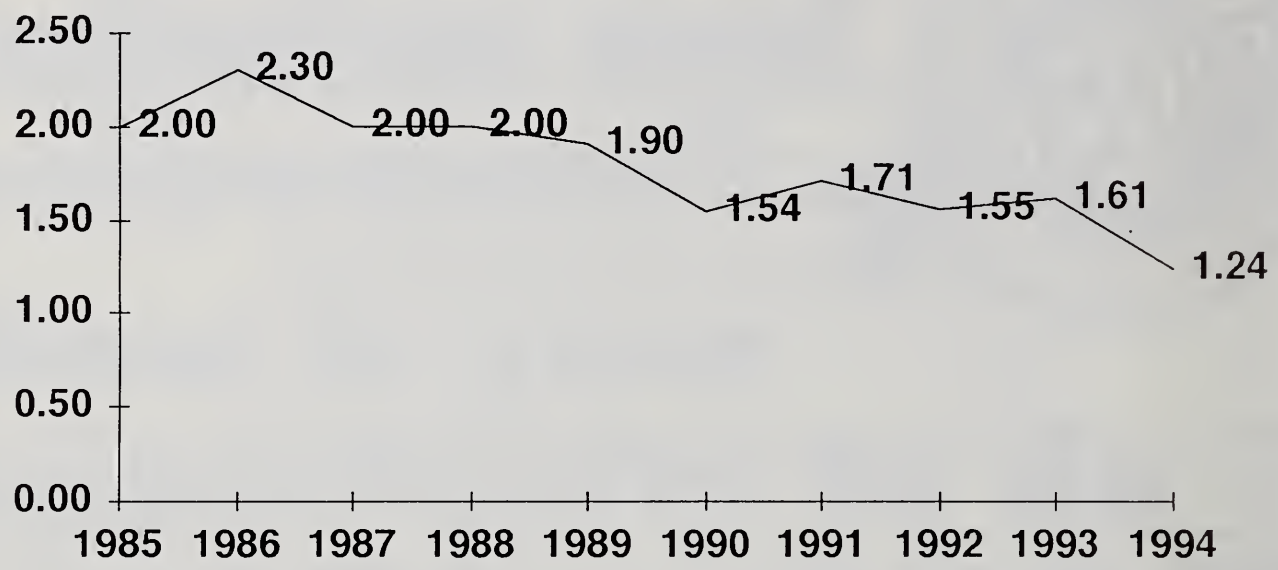


Figure 2

'Back to Sleep' Campaign Messages

- Place your baby on its back for sleep.
- Make sure your baby is sleeping on a firm mattress or other firm surface.
- Do not overbundle your baby, and keep the baby's room temperature comfortable.
- Avoid exposing your baby to cigarette smoke.
- Obtain good prenatal care for yourself and regular medical care for your baby.

Features of infant sleep vary by position. The prone sleep position involves having the face down at intervals, resulting in CO_2 rebreathing and, in some cases, hypoxemia.[13] Other studies have shown that the prone sleep position alters an infant's temperature regulation and heat exchange.[14] Qualitative sleep features vary by sleep position as well. The prone sleep position is associated with an increase in total sleep duration and longer periods of non-REM sleep, which has fewer arousals.[15] In the vast majority of instances, these sleep-state alterations pose no threat. However, infants vulnerable to SIDS may encounter potentially life-threatening physiologic stressors when in the prone sleep position.

Recent studies have suggested that the side sleep position may result in a risk for SIDS that is lower than the risk associated with the prone position but still greater than the supine position risk.[16] For that reason, international campaigns have recently emphasized supine sleeping exclusively.

The decline in SIDS rates associated with adopting the supine sleep position reinforces the message of the "Back to Sleep" campaign (see Figure 2). However, many infants who sleep on their backs and have no discernible risk factors do die from SIDS. Research focusing on infant developmental neurobiology is critical to our understanding of this continuing problem.

The Minnesota Sudden Infant Death Center

The Minnesota SID Center provides information and counseling to families who have lost a child to SIDS. The center also participates in educational and research activities focused on SIDS and infant mortality. The center, which began in 1976, is jointly sponsored by the Minnesota Department of Health and Children's Health Care–Minneapolis. Questions related to SIDS or infant mortality may be directed to the center by calling 800/732-3812. MM

Patrick Carolan is medical director of the Minnesota SID Center. Kathleen Fernbach is the center's executive director, and Sharyn Larson is its coordinator. Junie Svenson is infant mortality consultant, Minnesota Department of Health.

Table

Changes in SIDS incidence: by geographic region

Site	Year	Rate	Year	Rate	+/- Change
Scotland	1990	2.40	1994	0.70	-71 %
Ireland	1990	2.00	1994	0.90	-55%
Norway	1992	2.70	1995	0.50	-81%
Denmark	1992	1.80	1995	0.30	-83%
Sweden	1992	1.10	1995	0.40	-64%
France	1991	1.90	1994	1.20	-37%
Netherlands	1982	0.99	1994	0.30	-70%
Victoria, Australia	1990	2.30	1995	0.6	-74%
Perth, W. Australia	1980-91	1.60	1993	0.70	-56%
N. Adelaide, S. Australia	1978-87	2.20	1991-95	0.90	-59%
New Zealand	1980s	4.00	1993	1.99	-50%
S. Alberta, Canada	1980s	2.02	1990s	1.17	-42%
United States	1990	1.48	1994	1.12	-24%
Maryland	1993	98	1995	65	-34%
Minnesota	1985	2.00	1994	1.24	-38%
New York—Upstate	1974	1.43	1984	1.00	-30%

Source: Fourth SIDS International Conference Abstracts

REFERENCES

1. Willinger M, Hoffman HJ, Hartford RB. Infant sleep position and risk for sudden infant death syndrome. Pediatrics 1994;93: 814-9.

2. Minnesota death investigation guidelines for infants 0-24 months old: background and implementation for local investigative personnel. Minnesota Department of Health, Division of Maternal and Child Health, Infant Mortality Reduction Initiative. March 1993.

3. Abstracts and Proceedings of Fourth SIDS International Conference. Bethesda, Maryland. June 1996.

4. Bak SM, Willinger M, Hoffman HJ, et al. Infant sleep practices: results from U.S. national surveys 1992-1995. Abstract of a paper presented at Fourth SIDS International Conference. Bethesda, Maryland. June 1996.

5. Carolan PL, Larson SA, Luxenberg MG. Factors associated with non-prone infant sleeping. Arch Pediatr Adol Med 1995;149(Suppl): P100.

6. Carolan PL, Moore JR, Luxenberg MG. Infant sleep position and SIDS: a survey of pediatric recommendations. Clin Pediatr 1995;34:402-9.

7. Filiano JJ, Kinney HC. A perspective on neuropathological findings and SIDS: the triple risk model. Biol Neonat 1994;65: 194-7.

8. Filiano JJ, Kinney HC. SIDS and brainstem research. Pediatr Ann 1995;24:379-83.

9. Kinney HC, Filiano JJ. The neuropathology of SIDS: a review. J Neuropath Exp Neurol 1992;51:115-26.

10. Kinney HC, Filiano JJ, Sleeper LA, et al. Decreased muscarinic

receptor binding in the arcuate nucleus in SIDS. Science 1995;269:1446-50.
11. Takashima S, Becker LE. Delayed dendritic development of catecholaminergic neurons in the ventrolateral medulla of children who died of SIDS. Neuropediatrics 1991;22:97-9.
12. Kinney HC, Brody B, Finkelstein DM, et al. Delayed central nervous system myelination in SIDS. J Neuropathol Exp Neurol 1991;50:29-48.
13. Chiodini BA, Thach BT. Impaired ventilation in infants sleeping facedown: potential significance for sudden infant death syndrome. J Pediatr 1993;123:686-92.
14. Fleming PJ, Levine MR, Azaz Y, et al. Interactions between thermoregulation and the control of respiration in infants: possible relationship to sudden infant death. Acta Paediatr 1993;389:57-9.
15. Kahn A, Groswasser J, Sottiaux M, et al. Prone or supine body position and sleep characteristics in infants. Pediatrics 1993;91:1112-5.
16. Fleming PJ, Blair PS, Bacon C, et al. Environment of infants during sleep and risk of the sudden infant death syndrome: results of 1993-5 case control study for confidential inquiry into stillbirths and deaths in infancy. BMJ 1996;313:191-5.

Affiliated COMMUNITY Medical Centers, P.A.

Join the security of a large multispecialty group located in Southwest and West Central Minnesota Communities of 3,700 to 19,000. All areas flourish with four-season recreational opportunities, strong economies and excellent education where family and lifestyle are a priority. Outstanding benefits for BE/BC physicians in:

Dermatology
Family Practice
General Surgery
Internal Medicine
Neurology
Ob-Gyn
Orthopedic Surgery

Contact: Janiece Durham
Physician Recruitment Coordinator
Affiliated Community Medical Centers
101 Willmar Avenue SW
Willmar, Minnesota 56201-3591
320-231-6366

Neurologist & Oncologist

There are immediate openings at Brainerd Medical Center for a Neurologist and an Oncologist.

Brainerd Medical Center, P.A.
- 35-Physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162 bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota
- In the middle of the premier lakes of Minnesota
- Located in central Minnesota less than 2 1/2 hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:
- Curt Nielson
  (218) 828-7105 or
  (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

A Healthier Future

Southern Minnesota

*Seeking quality primary care trained or emergency medicine physician(s) to practice in **Fairmont, Owatonna and Worthington.***

- Stellar Emergency Medicine Practice
- Full-time, regular part-time and moonlighting opportunities
- No restrictive covenants
- Fully accredited CME programs
- St. Paul malpractice insurance
- Competitive bonus, benefit and compensation packages.

ACUTE CARE, INC.

Respond to Melissa Milliken, CMSC, Director of Development, 515-964-2772, 800-729-7813 or send CV to P.O. Box 515, Ankeny, Iowa 50021.

Residency: A View of the Distant Destination

The books "Residents: The Perils and Promise of Educating Young Doctors" and "Life After Medical School" offer personal snapshots of medical training and professional insights into what residents can expect.

Charles R. Meyer, M.D.

Most medical students know life beyond medical school as a foreign land, the distant destination after a long journey. Cadavers and coenzymes bear dim resemblance to patients and practice. (My first-year medical school roommate used to say the closest he came to clinical medicine was the medicine section of *Time* magazine.) Although medical schools in recent years are giving medical students earlier glimpses of clinical medicine, most students navigate their way into the future themselves and find a focus for their careers by graduation. How they make their choices and what they will face in the next stage of their training is the subject of two recent books, "Residents: The Perils and Promise of Educating Young Doctors," by David Ewing Duncan (Scribner, 1996) and "Life After Medical School," by Leonard Laster, M.D. (W.W. Norton, 1996).

Residency should be faintly familiar territory for medical students. They have worked closely with interns and residents on clinical rotations. They should know the sleep-deprived, vacant stare, the dreaded ER page, and the mountains of scut. But reality beats observation, and the jolt for first-year trainees is seismic. Residency is stressful by almost any account.

Duncan is a journalist who describes residency through the eyes of his pediatrician wife. The experience left quite an impression. He saw his wife and her colleagues enduring a trial that he compares to military school hazing. Reacting to the inhumane hours, the paltry pay, and the Attila-the-Hun school of teaching they endured, Duncan set out to discover why the training of future doctors had to be so grueling. Defenders of the traditional system cited several rationales: exposing residents to a wide range of clinical experiences in a short time, developing residents' sense of responsibility for the patient, preparing them for the future rigors of practice, and meeting the economic dictates of running teaching hospitals.

Duncan found these rationales wanting and wrote a well-documented analysis of the pitfalls of residency training. "Residents" reads like a slow installment of "ER" only because the life-threatening emergencies are not quite so densely packed. Duncan's portrait of incessant beepers and endless paperwork eroding haggard residents evokes weariness in even the most well-rested reader. His main theme is that 90-hour work weeks promote neither resident education nor safe patient care. Fatigue was not the only pathology Duncan observed. He also saw mistakes treated as inevitable and random, rather than preventable. He saw a hierarchical teaching system in which arrogance masqueraded as erudition and knowledge was valued more than common sense. He saw technical zeal crowd out human empathy. Most important, he saw residents not knowing what they didn't know or being too scared to admit it.

Following his journalistic instincts, he devotes much ink to describing the Libby Zion case in New York, where a young woman on an MAO inhibitor died of malignant hyperthermia when the residents treating her failed to realize potentially lethal drug interactions. Although the case ended in an equivocal legal judgment, the ensuing publicity sparked the Bell regulations that limited the weekly working hours for residents in New York state.

Despite superfluous 1 a.m. scenes of frantic doctors and tedious detail on the Zion case, Duncan argues a good case. His prescription for improvement includes limits on residents' working hours, more attending presence in patient care, more formal teaching of procedures, more gradual transfer of responsibility to new residents, and more emphasis on teaching and practicing compassion toward patients.

In Leonard Laster's book, "Life After Medical School," residency survivors speak about their journey through medical training into medical practice. Twenty-nine first-person autobiographies chart practitioners' decisions about their specialties. We hear the expected: surgeons choosing surgery because they like to work with their hands and fix things immediately, internists choosing in-

ternal medicine for the intellectual challenge and people contact, pathologists and radiologists choosing their fields for the lack of patient contact. We hear the intriguing: Peter Kramer, author of "Listening to Prozac," relating his conversion to psychiatry from the couch of his psychoanalyst, and P. Roy Vagelos, M.D., describing his path to CEO of Merck via medical school. And we hear the familiar: gripes about the hassles and headaches of the nonpatient side of medicine.

Laster's choice of physicians is less than representative. Laster himself is a professor at the University of Massachusetts Medical Center, and most of the physicians he interviewed inhabit Eastern academic medical circles. This group, preselected by their career choices and skewed in their educational backgrounds (many are from Harvard and Yale), is certainly accomplished but doesn't offer a breadth of personal and professional outlook.

Yet "Life After Medical School" does offer nuggets of insight about medical practice in the '90s. Here are a few. Steven Schroeder, Robert Wood Johnson Foundation president: "Work with people whom you like and trust and who will tell you the truth. Put what you're doing in a broad perspective, try to see how the parts connect, and grasp the purpose of what you're doing without being sidetracked by petty harassments and minor details that always crop up. Some people call that vision. ... Have a good time."

Arnold Relman, M.D., retired editor of the *New England Journal of Medicine*: "The current discomfort and unhappiness among physicians is a temporary inevitable manifestation of a major transition in the organization and orientation of medical care in this country. The role of physicians will not change, and the satisfactions that physicians get from the practice of medicine will always be there."

These books may look like travel brochures for what lies ahead for medical students. But the personal snapshots and professional insights make them worth perusing. MM

Charles Meyer is editor-in-chief of Minnesota Medicine *and an internist with Consultants–Internal Medicine in Minneapolis.*

First Call Physicians, Inc.
A Locum Tenens Service
500 Eighth Ave. S.
Buffalo, MN 55313

Clinics/Hospital | **Physicians**

Locums Coverage
=
Revenue

- Patients falling through the gaps?
- Physician burnout or illness?
- Shortage of physicians?

- Earn more with less time.
- No administrative headaches.
- Malpractice premium paid.

Experience, Service, Honesty
Call (metro) 682-3852
(toll free) 888-682-3852

(You'll be glad you did!)



SKI CASCADE LODGE...

LOCATED IN THE HEART of the North Shore Cross Country Ski trail. Cascade Lodge has log cabins, fireplaces, some with whirlpools, rooms in the lodge and a great family restaurant. Cross country ski the miles and miles of groomed trails at Cascade or downhill ski at Lutsen Mt. Ask us about lodging for groups too.
Call or write us for reservations.
HC3 Box 445 Lutsen, MN 55612

CASCADE LODGE
218-387-1112 1-800-322-9543

Special Early Factory Order Pricing on New 1997 Sport Utility Vehicles Through MMBR Motor Services

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED

Remember, whether you purchase or lease, MMBR Motor Services and Creative Leasing, Inc. will help you get the most vehicle at the best price. We'll even help you sell your old auto.

Use your money wisely. For personal attention and lease or purchase information on any vehicle, call 612/623-2860, or toll-free 800/298-MMBR.

MMBR Motor Services is a service of Minnesota Medical Business Resources, a physician-owned corporation of your medical association.

New Vehicle Leases**

Make/Model	MSRP	Your Price*	24 Mo	36 Mo	48 Mo	60 Mo
97 GMC Jimmy SLS 4dr	$27,072	**$24,904**	$433	$371	$345	$326
97 Chevrolet Blazer LS 4dr	$27,482	**$25,251**	$411	$353	$316	$308
97 Ford Explorer XLT 4dr	$28,880	**$26,025**	$423	$371	$348	$338
97 Jeep Grand Cherokee Laredo	$28,188	**$26,149**	$455	$394	$348	$330
97 Nissan Pathfinder SE	$30,618	**$28,268**	$483	$413	$370	$347
97 GMC Yukon SLE 4dr	$32,999	**$31,327**	$477	$422	$391	$375
97 Chevrolet Tahoe LS 4dr	$32,935	**$31,270**	$476	$421	$391	$375
97 Chevrolet Suburban 1/2 LS	$36,457	**$34,293**	$554	$483	$444	$423
97 Toyota 4-Runner SR5 4dr	$31,953	**$30,549**	$544	$457	$411	$382
97 Mitsubishi Montero LS 4dr	$31,690	**$30,361**	$510	$446	$455	$418
97 Ford Expedition XLT 4dr	$33,845	**$31,159**	$409	$390	$378	$361

Sale price before tax, license, license fees, and 1997 price increase.

* All lease payments listed above are monthly lease payments before tax on factory ordered leases. These lease payments are based on a $0.00 cap reduction and 15,000 miles/year. The only moneys needed to start the above leases are first payment, security deposit, and license for the first year.



MMBR

MOTOR SERVICES

MINNESOTA MEDICAL BUSINESS RESOURCES

OWNED BY MMA & HMS

People and Places Making Medical News

People

Health Lobbying Firm

Dave Durenberger and **Susan Bartlett Foote**, his wife and one-time policy aide, opened a health lobbying firm in Washington, D.C. The firm has four staff members and focuses exclusively on health policy.

Their client list includes Allina Health Systems of Minnetonka, St. Jude Medical Inc. of St. Paul, and the Fairness in Medicare Coalition, a group of 35 health care organizations that addresses Medicare inequities between states.

House Health, Budget Panel for Gutknecht

Gil Gutknecht, U.S. representative from Minnesota, was named to a health care-budget working group that helps the Budget Committee set overall fiscal priorities for the House. Gutknecht, a Republican, plans to direct policy discussions toward the private sector and empower people to be better buyers. "There are plenty of dollars available for health care," he said in a Twin Cities-based *Star Tribune* article. "They are just spent unwisely."

Bone and Marrow Transplantation Society President-Elect

John Kersey, M.D., director of the University of Minnesota Cancer Center, has been named president-elect of the American Society for Blood and Marrow Transplantation. His term as president will begin in March 1998.

Kersey and **Drs. William Krivit, Norma Ramsay**, and **Philip McGlave** developed the university's Bone Marrow Transplantation program, which pioneered the use of bone marrow transplantation in lymphoma, leukemia, and other diseases.

Kersey is a professor in the departments of Laboratory Medicine and Pathology, Pediatrics, and Therapeutic Radiology at the university. He has authored or coauthored more than 400 peer-reviewed publications.

'U' School of Dentistry Dean

Michael Till, D.D.S., professor of preventive sciences, has been named dean of the University of Minnesota School of Dentistry. Till, a university faculty member since 1970, has been interim dean of the school since July 1996.

He is past president of the Minnesota Dental Association and has served on the board of trustees of the American Dental Association. A former chair of the school's Department of Pediatric Dentistry, Till is known for his advances in teaching future dentists preventive care for children. In 1982, he founded the school's No Cavity Clinic, one of the first clinical programs in the country to focus on preventive dental care.

Nyberg Adviser to War on Tobacco

LuAnn Nyberg, former director of external affairs at United HealthCare, has joined Minnesota Attorney General **Hubert** (Skip) **Humphrey**'s case against tobacco companies. As public health adviser, Nyberg will coordinate public health experts, stock analysts, lawyers, health insurers, and other stakeholders to decide on acceptable terms of any settlement with the tobacco companies.

Her position is being funded by the foundation for Allina Health System, the state's largest HMO. Founder of the Children's Defense Fund–Minnesota, Nyberg was instrumental in the development of MinnesotaCare.

Places

Colorectal Cancer Initiative Underway

Physicians with Colon and Rectal Surgery Associates, Minnesota Gastroenterology, and the University of Minnesota Cancer Center have formed the Minnesota Colorectal Cancer Initiative to identify and help patients at high risk of developing colorectal cancer because of a family or personal history of the disease.

The announcement coincides with new national screening and surveillance guidelines, which are based in part on a landmark 1993 University of Minnesota study that showed that annual tests for blood in stools can reduce colorectal cancer mortality.

Colorectal cancer is the third most commonly diagnosed cancer and the second leading cause of cancer death in the United States. In 1996, physicians diagnosed about 2,400 new cases in Minnesota, and 970 people died from the disease.

'U' Program to Increase Rural and Urban Providers

The University of Minnesota, in collaboration with seven colleges across the region, received a five-year, $1.3 million grant from the Robert Wood Johnson Foundation to develop long-distance education programs for nurse practitioners, certified nurse midwives, and physician assistants.

Minnesota's Partnerships for Training Project aims to increase the recruiting of health care professionals through more accessible training, Internet courses, interactive television, and community-based clinical internships. Students will be able to complete the majority of their education without leaving their hometowns.

Participating schools are Augsburg College in Minneapolis, the College of St. Catherine in St. Paul, the College of St. Scholastica in Duluth, Winona State University, Mankato State University, Metropolitan State University in St. Paul, the University of Minnesota, and the University of Wisconsin–LaCrosse in conjunction with Mayo Foundation and Gundersen Medical Foundation. The Minnesota Office of Rural Health and Primary Care and the university's Rural Health School are also partners in the project.

'U' Moves Health Care Program to Business School

The University of Minnesota has moved its health care administration program to the Carlson School of Management. The program, which ranks among the five best in the country, had its home for 50 years in the School of Public Health. George Johnson, Ph.D., heads the two-year degree program, which currently enrolls 60 students.

"The change in the program was driven by the health care community and the program's alumni," said Carlson School Dean David Kidwell, Ph.D., in a Twin Cities-based *Star Tribune* article. "New leadership needs to understand medicine and people, and at the same time they have to manage it in a more businesslike manner."

HOI and FHCE Merge

The Health Outcomes Institute (HOI) and the Foundation for Health Care Evaluation (FHCE) have merged to form Stratis Health, based in Bloomington.

HOI, a spin-off of InterStudy, has worked with employer groups, managed care organizations, and providers to measure the outcomes of care. It has emphasized the use of patient-reported data, merging these with clinical and administrative data. FHCE has used billing data and information from medical records to assess the quality of care for Medicare beneficiaries in Minnesota. "This merger positions us to provide a comprehensive approach to collection and interpretation of data about the processes and outcomes of health care," said David Ziegenhagen, head of the new organization and former chief executive officer for FHCE.

HealthEast Offers Alternative Medicine at Maplewood Site

HealthEast plans to have an "integrative" health center in a Maplewood mall. The Healing Center, due to open this month, will be the first Minnesota health system to offer Western and alternative treatments.

The 9,000-square-foot center will operate seven days a week. A retail store will stock herbal teas, books, tapes, and natural medicines. Six days a week, HealthEast staff and independent practitioners will provide professional services that include traditional Western medicine, acupuncture, massage,



ST. CLOUD MEDICAL GROUP, P.A.

St. Cloud Medical Group,
a 38-physician multi-specialty clinic, is now recruiting BC/BE physicians in the following specialties:

- **Pediatrics**
- **Family Practice**
- **Urgent Care**

Guaranteed first-year salary. Production program thereafter with a full fringe benefit package.

If interested in joining a progressive medical clinic in central Minnesota, call or send CV to:

Daryl G. Mathews
Administrator
St. Cloud Medical Group
1301 West St. Germain
St. Cloud, MN 56301
(320) 251-8181

ASPEN Medical Group

Family Practice
Internal Medicine
Full-Time Urgent Care

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

"We love it here. Depending on the season, we're minutes from skiing or hiking."
Rita Hsu, M.D.



WASHINGTON

The Wenatchee Valley Clinic, a prominent 140+ physician, multi-specialty group practice in the Pacific Northwest has several practice opportunities throughout its practice locations. **Currently, we are seeking:**

WENATCHEE

- **Family Practice w/ OB**
- **Pediatrician**
- **Neurosurgeon**
- **Infectious Disease**
- **Radiation Oncology**
- **Cardiologist**
- **Pathologist**

OMAK/MOSES LAKE

- **Family Practice w/OB**
- **Obstetrician**
- **Ophthalmologist**
- **Urgent Care**
- **Dermatologist**
- **General Internist**
- **Gastroenterologist**

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Send C.V. to the attention of Fred Bockenstedt, M.D., Medical Director -

P.O. Box 489, Wenatchee, WA 98807
FAX (509) 664-7178
CALL (509) 663-8711 ext. 5203

Wenatchee Valley Clinic

LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell
Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
or 800-295-6373
Fax: 682-4791

nutritional and spiritual counseling, guided imagery, and healing touch.

The center will not be a primary care clinic, according to **Chris Foley, M.D.**, the center's medical director. He and administrative director **Anne Hannahan** emphasize that they will work with patients' primary care doctors, not compete with them.

Foundation to Research Early Diagnosis of Uterine Cancer

The American Cancer Society has awarded the Minneapolis Medical Research Foundation (MMRF) a $200,000 grant to research a promising new method for the early diagnosis and potential treatment of uterine cancer. The disease is the country's fourth most frequent cancer in women, with about 34,000 new cases and 6,000 deaths reported annually.

The research will investigate a marker expressed during the development of uterine cancer. This marker could help alert physicians to the disease earlier than currently available detection methods. The marker also could help researchers identify a specific target for cancer-killing drugs. Screening techniques used in this research study also will be expanded to include breast and prostate cancers; early detection of these cancers is critical to successful treatment. **Anil Kaul, M.D., D.D.S.**, director of research for MMRF's Department of Obstetrics and Gynecology, will lead the study.

Socioeconomics

Study: Health Insurance Shorts Women

A study by **Steven Miles, M.D.**, medical ethicist at the University of Minnesota Center for Biomedical Ethics, indicates that Medicare and Medigap insurance plans provide better coverage for illnesses more common in men, such as lung cancer. The study appeared in the January 16 *New England Journal of Medicine.*

As a group, women have less health coverage, pay more out-of-pocket, and are more likely to lose insurance for periods of time, according to Miles. One of his studies showed that three of the four illnesses with the highest out-of-pocket costs—arthritis as one example—were more common in women than in men. At the same time, four of the five treatments with the lowest costs to patients were more common in men.

Inequities also exist with private insurers. Women were twice as likely as men to be uninsured for some period of time, in part because they're likelier to change jobs for family reasons. Women also tend to work for smaller companies, which have limited health benefits. Miles indicated that insurers can correct these inequalities by taking gender into account in designing health policies.

BHCAG Expands Market

The Sioux Empire Employers Health Care Group, a coalition of 11 private and public employers, has joined the Buyers Health Care Action Group (BHCAG), which offers experimental employee health benefits programs in the Twin Cities. The coalition will introduce BHCAG's program in the Sioux Falls area in 1998.

The partnership will provide some of Sioux Falls' largest employers with a new way of controlling benefits and costs by allowing them to contract directly with clinics and hospitals, rather than go through HMOs or other health plans.

In the Twin Cities area, BHCAG has contracted with 15 care systems, including most large clinics and hospitals. Employees choose among them, paying higher premiums to use more expensive systems. BHCAG has 26 Twin Cities area-based members, and several of its members have operations in the Sioux Falls area.

Task Force Urges Charting Injuries

A state-sponsored task force is urging Minnesota hospitals to record the cause of injuries, which account for 40 percent of all emergency department visits. Injury is the No. 1 killer of people between the ages of 1 and 44. At least 15 other states require collecting such data.

Janny Brust, director of population-based initiatives at Allina Foundation, indicated that implementing a data collection system is straightforward and inexpensive. National standards already exist, and most insurance forms have a space for recording that information, said Brust, who cochaired the task force sponsored by the Health Care Coalition on Violence.

Currently, hospital staff record diagnostic codes that private and government insurers require for reimbursement. Brust hopes to educate hospitals to use "E codes," which show the external cause of the injury.

Twin Cities Health Care Costs on the Rise

Health care costs in the Twin Cities increased faster than those in the rest of the nation last year, according to a national survey.

Health benefits costs for 56 Twin Cities employers with more than 500 employees rose 5.8 percent over 1995, to an average of $4,019 per employee, reported Foster Higgins, a benefits consulting firm. Nationwide, these same benefits rose 3.6 percent, to an average of $4,332 per employee.

"The one-time savings from employers moving into managed care has been taken," said **Blaine Bos**, a principal at the firm, in a St. Paul *Pioneer Press* article. "Now we're seeing the real cost of providing health care."

In the Twin Cities, HMOs had the lowest increase in costs, at 1.2 percent, according to the survey, while traditional indemnity insurance plans rose the fastest, at 17.5 percent.

The Perfect Fit...

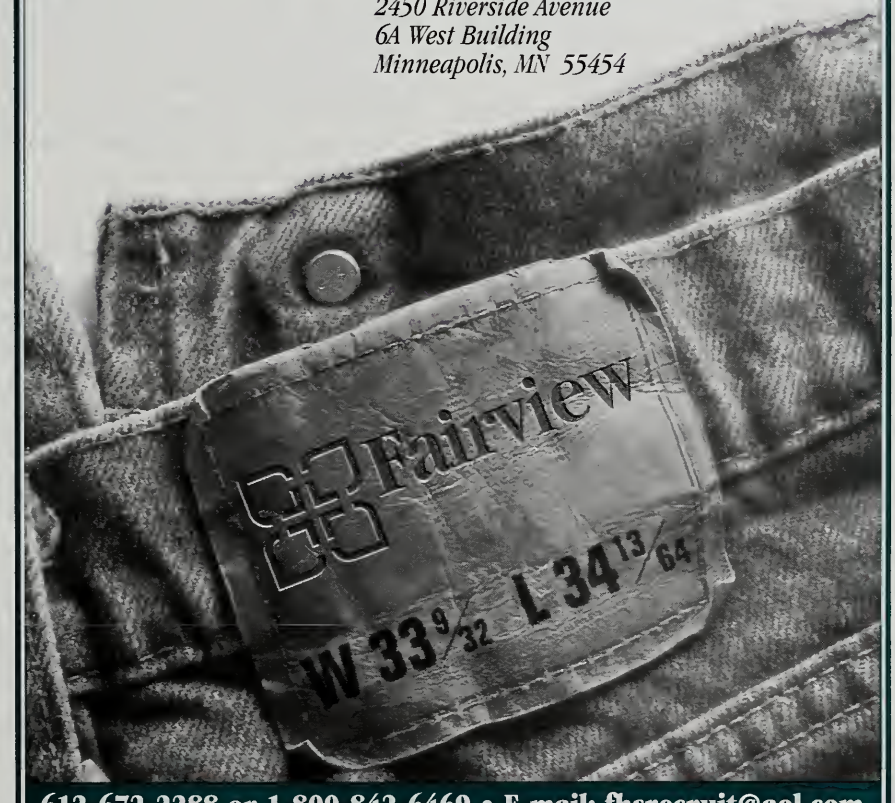
...is a rare find. Fairview Health System represents a wide spectrum of practice and lifestyle options in Minnesota. We will help you locate opportunities that are tailored to fit your needs in communities that match your size.

Opportunities now available in communities large, medium and small (and sizes in between) for...

- **Endocrinology**
- **Family Practice**
- **General Surgery**
- **Internal Medicine**
- **Obstetrics/Gynecology**
- **Orthopedic Surgery**
- **Urgent Care**
- **Urology**

Fairview

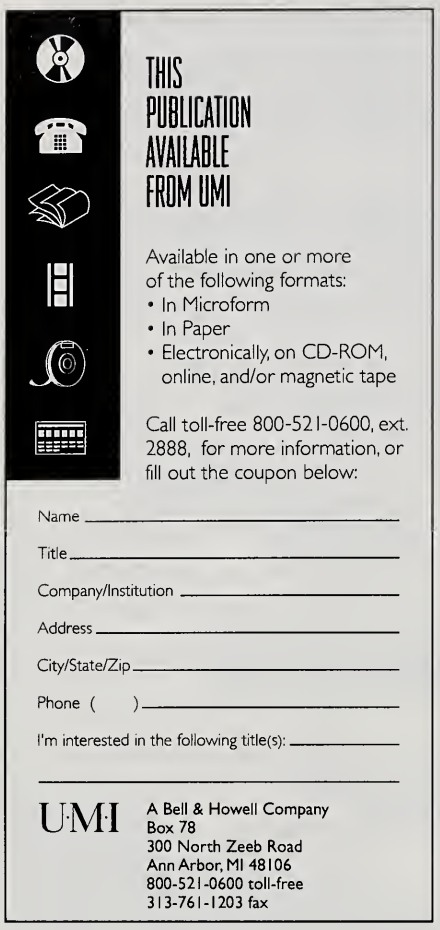
Physician Recruitment & Retention Dept.
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454



612-672-2288 or 1-800-842-6469 • E-mail: fhsrecruit@aol.com

State Nursing Home Rates Higher Than Neighbor States'

Minnesota pays nursing home rates that are 15 percent to 30 percent higher than what neighboring states pay, making its rates 13th highest in the nation, a legislative auditor's study reported. The difference in rates is due to sicker patients, more nursing staff, and



higher wages, according to **Susan Von Mosch,** who headed the study.

Minnesota paid an average of $95.61 a day in 1995, compared with Wisconsin's $83.15 a day. The Minnesota Department of Human Services is trying to reduce nursing home care costs. One effort has the state moving away from a cost-based payment system and contracting directly with 73 nursing homes. Minnesota is also trying to lower its costs by melding Medicare and Medicaid payments for nursing home residents covered by both programs.

Minnesota's spending on nursing home care for medical assistance patients is projected to rise nearly 9 percent this year and to continue rising at about 3 percent annually for the next several years.

HealthSpan Home Care for Kids Open Until July 1

HealthSpan announced it will continue its pediatric home care nursing program until July 1. The HealthSpan Home Care and Hospice, which serves 21 families of severely disabled children, was scheduled to close February 2 because of inadequate reimbursement levels for nurses. The July 1 extension of services should allow the government to raise reimbursements levels enough so the program can at least break even. Parent company Allina Health System will absorb the losses for the next four months.

Blue Plus Changes Referral Policy

Blue Cross and Blue Shield of Minnesota announced a policy change that will allow women in its Blue Plus HMO to see obstetricians and gynecologists without referrals. The change reverses the restriction that required women to get a referral from a primary care physician. About 100,000 women enrolled in the HMO will be affected.

The Twin Cities two other large HMOs, Medica and HealthPartners, already have policies allowing women to see ob/gyns without a referral.

United HealthCare Offers Seniors Portable Benefits

United HealthCare Corp. will offer a portable benefits program for seniors who are enrolled in some of its Medicare HMOs. The program allows United's Medicare members to use their health plan benefits at 18 participating United HealthCare sites throughout the United States.

Most HMOs allow only emergency care outside of the enrollee's home area. Known as the United Health Passport, the program is the first of its type the federal government has approved.

Smoking Is Costly for Minnesota

Minnesota's Medicaid program paid out $1.3 billion for the treatment of smoking-related illnesses during a 14-year period, according to researchers of an unpublished report the St. Paul *Pioneer Press* obtained. The research team includes **Leonard Miller,** an economist from the University of California–Berkeley, who will serve as an expert witness for the state in its lawsuit against tobacco companies. The preliminary estimate does not represent the undisclosed damages Minnesota will seek in the lawsuit.

In the lawsuit, Attorney General **Hubert Humphrey III** and Blue Cross and Blue Shield of Minnesota seek reimbursement for treating such smoking-related illnesses as lung cancer, heart disease, and emphysema. The case will begin next January in Ramsey County District Court.

Rates, Trends, Data

Hospital Staff Injuries Rising

The number of injuries and illnesses among registered nurses in Twin Cities metropolitan area hospitals increased 65 percent from 1990 to 1994, according to a report compiled by the Minnesota Nurses Association. Licensed practical nurses and nursing assistants saw similar increases in injuries, and unlicensed personnel such as surgical technicians, dialysis technicians, and respiratory therapists saw increases of 116 percent.

Cuts in nursing staffs have left fewer nurses caring for more patients—many of them seriously ill and some dangerous, said **Elizabeth Shogren,** a registered nurse and labor relations specialist with the association. The increase in illnesses and injuries serious enough to require first aid occurred even though the total number of nurses dropped more than 9 percent, largely because of layoffs at hospitals, according to a Twin Cities-based *Star Tribune* article.

The nursing association report is based on information 12 Twin Cities hospitals filed with the

Occupational Safety and Health Administration.

NYC Reports Sharp Decline in AIDS Deaths

New York City experienced an unexpectedly sharp decline in AIDS deaths last year, according to public health officials, who speculate that the decrease is the result of a combination of new treatments and an increase in federal funding for services for AIDS patients. Nationally, the number of AIDS deaths is leveling off.

Minnesota also saw a significant drop in AIDS deaths during the second half of 1996, according to Health Department officials. "The most likely reason is the new treatment modalities," said **Buddy Ferguson,** Health Department spokesperson.

Since the second half of 1992, the number of AIDS deaths in Minnesota has averaged more than 100 for each six-month period. That trend continued until the second half of 1996, when the number of AIDS deaths dropped to 59. Health Department officials expect this number to increase by another 10 or 20 deaths once all data are compiled.

The information on New York's decline was presented in January at the Fourth Conference on Retroviruses and Opportunistic Infections, a major AIDS meeting in Washington. Despite the good news, officials warn that the overall drop in death rates masks a major increase in AIDS cases and deaths among heterosexual women and minorities.

U.S. Physician Population Growing, Profile Changing

The number of physicians in the United States continues to grow, reaching 720,325, according to the American Medical Association (AMA). Although more than three-quarters of those physicians (79.3 percent) are male, the number of female physicians (149,404) increased 1.2 percent over 1994.

Nearly one-half of U.S. physicians are under 45 years of age and nearly one-quarter are graduates of foreign medical schools. Most physicians practice in metropolitan areas, while the number of U.S. counties without a practicing physician (155) is also growing.

U.S. Ranks as Most Violent Nation for Children

The United States has the highest rates of childhood homicide, suicide, and firearms-related deaths of any of the world's 26 richest nations, the Centers for Disease Control and Prevention (CDC) found. Many other nations reported no homicides involving children under age 15.

Etienne Krug, M.D., medical epidemiologist who conducted the study, said some researchers have given as reasons low funding levels for social programs, high numbers of working women, high divorce rates, and social acceptability of violence in the United States. Krug added to that racism, poverty, and unequal opportunity.

Medical Research

Study Examines Patient Use of Cancer Screening Tests

Studies since 1993 confirm that patients who see women physicians are more likely to undergo cancer screening tests than patients who go to men physicians. A report by Minnesota researchers in the January *Journal of General Internal Medicine* offers an explanation. Two factors seem to contribute to the higher rate. The first is differences in beliefs of male and female physicians. The second is differences in attitudes among women patients themselves; those who preferred a female physician had higher screening rates.

Female physicians were found to have more favorable attitudes and beliefs about prevention and were more likely to report "always" asking new patients about elements of prevention. They reported taking more responsibility for screening patients who were seeing both them and another physician. They also were significantly more likely to believe in the effectiveness of annual mammography for women over 50 and to spend more time with their patients, according to the study, directed by **Nicole Lurie, M.D.,** an internist at Hennepin County Medical Center.

Safety Needles Reduce Hospital Workers' HIV Risk

Hospital workers who use plastic-sheathed hypodermic needles instead of conventional needles can reduce their risk of contracting AIDS by as much as 75 percent, according to a study of three Twin Cities hospitals. Researchers found that the number of accidental needle sticks was 3.6 per 100,000 blood draws with a standard hypodermic needle compared with .9 per 100,000 with the sheath-covered needle.

But the cost of the safety needle—25 cents—compared to 8 cents for the standard needle is prohibiting hospitals from using them. The safety needle also takes more time to use, according to **Frank Rhame, M.D.,** the University of Minnesota's AIDS expert when the study was conducted between 1993 and 1995. "That adds to costs at a time when hospitals are under pressure to hold down spending," he said.

Keith Henry, M.D., head of the AIDS program at St. Paul-Ramsey Medical Center, indicated the cost will come down when managed care organizations buy large quantities of the safety device and pressure manufacturers to reduce prices.

Merits of Angioplasty Equal Bypass Surgery

Little difference in quality of life or cost exists between balloon angioplasty and coronary bypass surgery, researchers at Mayo Clinic and elsewhere have reported. Bypass patients have a slightly better quality of life during the first three years following surgery, but that advantage disappears by the

CONTOURS Rx

$1,000,000
CLINIC REVENUE INCREASE!
NO INCREASED CALL • NO INCREASED ROUNDS • PROTECTED GEOGRAPHIC AREA

How? • Contours complete multi-track programs of physician monitored weight loss and maintenence.

Includes: • Detailed medical research, protocols, and guidelines;
• A one-year program detailed by visit;
• A patient/client education package (paid by client);
• And complete support materials.

Successful results for the patient from medications, program learning, and behavior changes. Developed and tested successfully by Lakeside Medical Clinic.

Complete description and details by fax, call 612-537-1000 and ask for Contours details, or fax your request to 537-4852.

4600 Lake Road, Minneapolis, MN 55422–Primary Care Facility

Discover Greater Minnesota
through locum tenens!

Minnesota Rural Physician Support Program:

- High quality, not-for-profit locum tenens program
- Variety of rural opportunities
- Competitive wages

Contact: Minnesota Center for Rural Health
600 E. Superior Street, Suite 404
Duluth, MN 55802
Phone: 1-800-997-6685
Fax: (218) 727-9392
E-mail: mcrh@d.umn.edu
Home page: http://www.d.umn.edu/mcrh

Information on practice opportunities, loan repayment, compensation packages, and contract review also available.

Administered by the University of Minnesota and the Minnesota Center for Rural Health

end of five years, according to **Guy Reeder, M.D.**, director of Mayo's coronary care unit. Angioplasty costs about 35 percent less than bypass surgery, but again after five years the gap narrows to about 4 percent because some patients may need to repeat the procedure.

The five-year study appeared in the January 9 *New England Journal of Medicine*. One flaw in the study is that it started in 1988, before surgeons began installing stents in angioplasty patients. Reeder indicated that stents seem to be effective in keeping the arteries open, so the study's angioplasty results would have been much better had stents been part of the procedure.

Innovations

'U' Performs First Heart Remodeling Surgery

University of Minnesota physicians in January performed the state's first cardiac ventricular remodeling surgery at Fairview-University Medical Center. The procedure appears to be an attractive alternative to heart transplants for some patients with congestive heart failure.

The surgery corrected dilated cardiomyopathy, a form of heart disease that weakens the muscle and decreases its ability to pump blood, on patient **David Olene**. Surgeons **R. Morton "Chip" Bolman III, M.D.**, and **Soon Park, M.D.**, removed a portion of Olene's heart muscle, reducing the size of the left ventricle, the heart's main pumping chamber. The reduction restores the diseased heart to a shape that's closer to its natural shape, which allows it to pump blood more efficiently. Bolman is professor and Park assistant professor of cardiovascular and thoracic surgery.

Aggressive LDL Management Reduces Risk of Future Blockage

Heart bypass patients need a more aggressive regimen to lower their LDL cholesterol to reduce the risk of further blockages in the bypass graft, according to a study published in the January 16 *New England Journal of Medicine* by researchers at the University of Minnesota and medical centers across the United States and Canada.

Researchers tested 1,351 patients who had had bypass procedures one to 11 years prior and found that patients on a more aggressive cholesterol-lowering regimen (achieving LDL levels below 100 milligrams per deciliter) were less likely to develop atherosclerosis than those on a more moderate regimen (130-140 milligrams LDL per deciliter). MM

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

MARCH 1997

Mar. 6-7 **Current Issues in Phlebotomy and Point-of-Care Testing** Mayo Medical Laboratories; Renaissance Harborplace Hotel, Baltimore, MD. CONTACT: Kathy Bates or Julie McAdams, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

Mar. 7 **Osteoporosis Conference** Hennepin County Medical Center; Doubletree Grand Hotel, Bloomington, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Mar. 7-8 **Advanced Trauma Life Support Course** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Mar. 10-13 **Counseling the Compulsive Gambler: Phase I** Minnesota Council on Compulsive Gambling; New Orleans, LA. CONTACT: Elizabeth M. George, 314 West Superior Street, Suite 702, Duluth, MN 55802; 218/722-1503.

Mar. 13-14 **Research Statistics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Mar. 14 **Anticoagulation Therapies** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Mar. 14-15 **Current Issues in Cancer Prevention, Detection, and Treatment** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 21 **New Approaches in the Treatment of Addictive Disorders** University of Minnesota Continuing Medical Education; Sheraton Inn–Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

APRIL 1997

Apr. 4 **Case Studies in Cardiac Arrhythmias** University of Minnesota Continuing Medical Education; Earle Brown Heritage Center, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 4 **Fifty-fifth Annual Course in Allergy and Clinical Immunology** University of Minnesota Continuing Medical

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

CONFERENCES

Mar. 21 **HIV Primary Care Conference** Allina Health System, Children's Health Care, Duluth Clinic, Health East, Health Partners–St. Paul-Ramsey Medical Center, Hennepin County Medical Center, Institute for Research and Education–Health System Minnesota, Midwest Aids Training and Education Center, Minneapolis Education Center–Department of Veterans Affairs, and the University of Minnesota; The Metropolitan Conference Center, Minneapolis, MN. CONTACT: Allina Office of Clinical Education and Research, 612/992-2424.

Apr. 9 **Emerging Infectious Diseases** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance** Allina Health System. CONTACT: Don Young, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3824.

Videotapes: **Emerging Infectious Diseases** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Family Practice Variety

HealthPartners has a variety of opportunities for BC/BE family practitioners. These are primarily adult practices, some full range and some limited range, most in ambulatory settings. Urban or suburban practices are available.

HealthPartners Bloomington Clinic
Large suburban clinic located in Bloomington, just south of Minneapolis.

HealthPartners Riverside Clinic
Just outside of downtown Minneapolis, this clinic serves a widely diverse population.

HealthPartners Skyway Clinic
Downtown Minneapolis clinic practice involving no OB and limited peds.

HealthPartners Woodbury Clinic
Our newest clinic, located in the fastest growing suburb of St. Paul. Full range practice.

Ramsey Clinic Maplewood
Suburban location with a full range practice including peds with OB optional.

For more details on specific openings and clinic sites, contact Lori Fake at (612) 883-5337 or (800) 472-4695. For consideration, forward your CV to: HealthPartners, Physicians Services, P. O. Box 1309, Minneapolis, MN 55440-1309. EO/AA Employer.

HealthPartners

HealthPartners' mission is to improve the health of our members and our community

MMA-Accredited CME Sponsors

❧ The Minnesota Medical Association is the accrediting agency for Minnesota institutions that regularly sponsor continuing medical education activities for local physicians. ❧ Accreditation gives CME sponsors responsibility for conducting high-quality CME programs and for designating credit for CME activities. ❧ CME programs must comply with the MMA's "Essentials for the Accreditation of Sponsors of Continuing Medical Education" and the ACCME's "Standards for Commercial Support of CME" and "Standards for Enduring Materials." ❧

The MMA Committee on Accreditation and CME has recently reaccredited the following CME sponsors:

- ❧ HealthEast St. John's Hospital, Maplewood
- ❧ Olmsted Medical Center, Rochester

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800 DIAL-MMA.

Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 4-5 **Innovative Concepts for Stroke Care: Preparing for the 21st Century** St. Luke's Hospital and Regional Trauma Center; Holiday Inn, Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Apr. 10-12 **Hip and Knee Reconstruction: Controversies and State-of-the-Art** Mayo Foundation; The Pointe Hilton at Squaw Peak, Phoenix, AZ. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 10-12 **Home Care Medical Directors Training Seminar II** University of Minnesota Continuing Medical Education; Surf and Sand Hotel, Laguna Beach, CA. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 11-12 **Annual Ophthalmology Course** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 17-18 **Research Statistics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Apr. 17-19 **Medical Directors Training Program** University of Minnesota Continuing Medical Education; The Historic Brown Palace Hotel, Denver, CO. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 17-19 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

Apr. 24-25 **Broader Roles, Better Diabetes Care** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Kay Martin, 3800 Park Nicollet Boulevard, Minneapolis, MN 55416; 612/993-2879.

Apr. 25 **Learning Disorders Assessment Program** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 28-May 2 **Family Practice Review Update 1997** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615

Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

MAY 1997

May 2-3 **Cultural Diversity Conference** Hennepin County Medical Center; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

May 5-9 **Eighteenth Annual Practice of Internal Medicine** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

May 6-9 **Fourth International Surgical Pathology Symposium** Mayo Medical Laboratories; Hotel Estoril Sol, Cascais, Portugal. CONTACT: Kathy Bates, Mayo Medical Laboratories, Office of Continuing Education, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

May 11 **Preventive Medicine** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 12-14 **Mayo Clinic Nicotine Dependence Seminar: Counselor Training and Program Development** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

May 16 **John I. Coe Symposium** Hennepin County Medical Center; St. Cloud Civic Center, St. Cloud, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

May 17 **Retinal Update: Laser Photocoagulation of Retinal Diseases** Phillips Eye Institute; Minneapolis, MN. CONTACT: Leslie Gibson, Phillips Eye Institute, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061; fax 612/870-0315; E-mail gibson@allina.com

May 20-21 **Advances in Inherited Urea-Cycle** University of Minnesota Continuing Medical Education; Hotel Schloss Wilhelminenberg, Vienna, Austria. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 21-23 **Current Concepts in Radiation Therapy** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Obstetrician/ Gynecologist

There is an immediate opening at Brainerd Medical Center for an Obstetrician/Gynecologist.

Brainerd Medical Center, P.A.

- 35-physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota

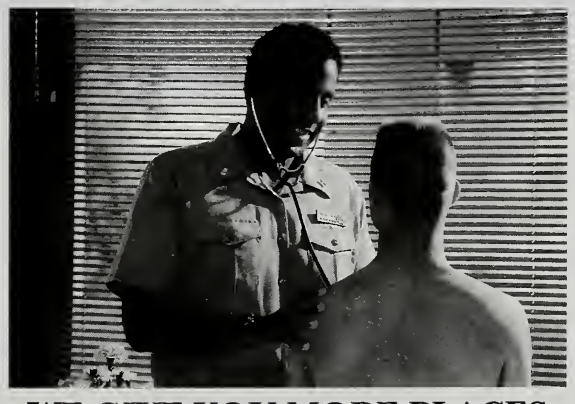
- In the middle of the premier lakes of Minnesota
- Located in central Minnesota less than 2 1/2 hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:

- Curt Nielson
  (218) 828-7105 or
  (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

EARN WHILE AN INTERN



WE GIVE YOU MORE PLACES TO GO WITH YOUR CAREER

The Navy is accepting applications for: Orthopedic, Family Practice, OB/GYN, Undersea Medicine, General Surgery, Anesthesiology, Flight Surgeon and others.

Location and Benefits:

- Excellent Salary And Benefits Packages
- Challenging Assignments
- Relocation Expenses Paid
- Professional Development
- Worldwide Location

FOR MORE INFORMATION CALL: 1-800-247-0507 (MN)
1-800-558-0068 (WI)

NAVY PHYSICIAN You and the Navy. Full Speed Ahead.

STILLWATER
MEDICAL GROUP, P.A.

Be a part of a rapidly growing community in the historic city of Stillwater, MN.

An opportunity is available for a board certified physician in General Surgery in the scenic St. Croix River Valley.

- 42-physician, multi-specialty clinic, with two clinic locations in Stillwater, MN
- Comprehensive benefit package
- Excellent school system
- Ideal for families
- Located near the banks of the beautiful St. Croix River

If interested please call or send CV attention:
Liz Junker, H. R. & Benefit Specialist
921 S Greeley St.
Stillwater, MN 55082
(612) 439-1234 Ext. 327

South Dakota
Room to Grow

Just imagine...the luxury of outdoor life in a traditional practice in Mitchell, South Dakota. The clinic is seeking a fifth BC/BE FP with OB. Quality family life, low crime rate...and No State Income Tax! Above national average compensation and comprehensive benefit package. Call today! Or send your CV to Pam Martin, Business Manager, Mitchell Clinic, 818 W. Havens, Mitchell, SD, 57301. 1-605-996-7772



May 24-29 **American Academy of Physician Assistants' 25th Annual Conference** American Academy of Physician Assistants; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Sharon Kirksey, American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; 703/684-1924 ext. 3405.

May 29-June 1 **Workshops in Clinical Hypnosis: Introductory and Advanced** University of Minnesota Continuing Medical Education; Sheraton Inn–Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JUNE 1997

June 6-7 **Optimizing Disease Management Through Pulmonary and Gas Exchange Diagnostics** University of Minnesota Continuing Medical Education; Marquette Hotel, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 11-14 **Fiftieth Anniversary Mayo Interventional Cardiology Symposium** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

June 18-20 **Topics and Advances in Pediatrics** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 18-21 **Sixty-first Annual Course: Advances in Gastrointestinal and GI Laparoscopic Surgery** University of Minnesota Department of Surgery, University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 18-21 **Annual Surgery Course: Advances in GI and Laparoscopic Surgery** University of Minnesota Continuing Medical Education; Willey Hall and Marriott City Center Hotel, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JULY 1997

Jul. 13-19 **Mayo Clinic Internal Medicine Board Review 1997** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jul. 20-22 **Update in Otolaryngology: Head and Neck Surgery** Mayo Foundation; Skamania Lodge, Stevenson, WA. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., March 15 for May ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Family Physician: Tired of call? Want predictable hours? Full-time physician needed to work three days per week in our ambulatory care centers located in Roseville, Minnetonka, and Eagan. Salary $80,000 minimum and benefits package including malpractice insurance. Also, looking for part-time physicians to cover for Sundays and vacations. Contact Cara Auge or William Wenmark, c/o NOW Care Medical Centers, 13031 Ridgedale Drive, Minneapolis, MN 55305; 612/593-9010. (10/93-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

Olmsted Medical Center is seeking BC/BE physicians in the following specialties: emergency medicine and family medicine. Great opportunity for well-trained physicians to join a 70-physician multispecialty group in a dynamic, progressive practice. Positions currently open include emergency room and family medicine departments in Rochester and branch office locations. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes nine branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (5/96-R)

Fergus Falls Medical Group is expanding its 33-physician multispecialty clinic and is seeking physicians in the following specialties: dermatology, family practice, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (1/97-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice-trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

Rent Our Caribbean-Shore Home—Silver Sands, Jamaica. Cook, maid, your own pool. Sleeps eight. Great for families, groups. Rent from $1,995/week winter, $1,395 off-season. 800/260-1120. (10/96-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Physician Needed to work part time in multidisciplinary clinic. All calls confidential to doctor's private line, 612/889-5973. (6/96-R)

Part-time Neurologist wanted for multidisciplinary office, no call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Family Physician—Parkview Medical Clinic in New Prague is recruiting. Rural town located 50 miles south of Minneapolis. Modern primary care hospital in town. New high school, community center, and fitness center. Two 18-hole golf courses. Strong industrial base. Highly desirable community. Excellent guaranteed salary. Contact: John Berg, M.D., 612/758-2535 (office) or 612/758-3000 (home) or write PO Box 186, New Prague, MN 56071. 2-4/97

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 25 member medical staff has openings in the areas of:

Family Medicine
Orthopedic Surgery
OB/GYN
General Surgery
Psychiatry
Podiatry

CHISAGO HEALTH SERVICES
A subsidiary of Fairview

Please contact:
Physician Recruitment and Retention Department
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454
1-800-842-6469

For Rent: Furnished four-bedroom Tudor home. Convenient Crocus Hill (St. Paul) location. Fireplace, original oak woodwork, study, TV room, brick patio, fenced sideyard, garage, $1,900 per month. Available August 15. Call 612/292-8268. 1-3/97

For Sale: Four-season cabin on Cross Lake (Whitefish chain). Excellent location, sandy beach, beautifully landscaped, low maintenance. Four bedrooms, three baths, 2,500 square feet; call 612/472-7884. 2-4/97

Vacation Rental: Three-bedroom cottage, Cross Lake. Whitefish chain. Excellent sand beach, tennis, sand volleyball, laundry, phone, cable, fishing boat. Two-week minimum. No pets. Call 507/526-2610 or 602/807-2854. *1-3/97

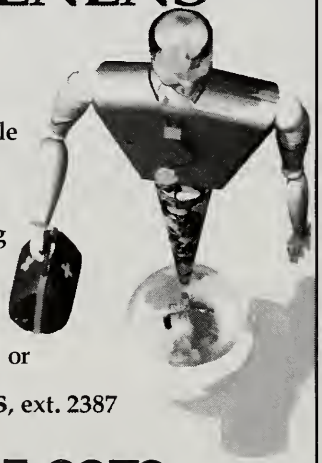
Family Practice: Primary care with a personal touch—that's Regina Medical Group. Our well-established group has an opportunity for a BC/BE FP with a committed, community-based practice approach to join our Hastings, Minnesota, or Prescott, Wisconsin, sites. Excellent call, salary, and benefits. Forward your CV to Mark Kapler, vice president, Regina Medical Group, 1175 Nininger Road, Hastings, MN 55033; 612/480-4219. 3-4/97

Luther/Midelfort–Mayo Health System, a 160-member physician directed multispecialty clinic and hospital, has openings for the following physicians: Eau Claire, Wiscon-

Staff Care, Inc.

"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS



- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging

Ask for :
John Moberly, ext. 2381 or
Melanie McReynolds, ext. 2387

(800) 685-2272
http://www.locumsnet.com

Staff Care is proud to sponsor *the Country Doctor of the Year Award*

Unable to place J-1 or H-1 physicians

PHYSICIAN INTERNAL MEDICINE

Move to St. Cloud, Minnesota and join the Internal Medicine practice of *WARREN H. LUEDTKE, M.D.* He is the sole physician in a well-established, independent clinic. Specialties of the practice include *INTERNAL MEDICINE AND PRIMARY CARE.*

Dr. Luedtke is a Member of The Minnesota Clinic, Central Minnesota's only physician owned and governed medical delivery system. The Minnesota Clinic exists to continue cost effective, quality health care through the private practice of medicine.

Consider the benefits of a well-established practice and the pleasures and practicalities of life in a small city on the Mississippi, flourishing with cultural, civic and family activities.

TO FURTHER EXPLORE A GREAT MOVE, CALL:

WARREN H. LUEDTKE, M.D.
108 DOCTOR'S PARK
ST. CLOUD, MN 56303
(320) 255-1799

MEMBER OF THE Minnesota CLINIC
Your Partner in Quality Health Care

sin, occupational medicine, urology, dermatology, pediatrics; Menomonie, Wisconsin, Red Cedar Clinic–Mayo Health System, four urgent/emergent family practitioners, orthopedic sports medicine, and general surgery. For more information, interested physicians may contact Christie Blink, Physician Recruitment Coordinator, phone 800/573-2580 or fax 718/838-6688. 1-3/97

District Medical Director: Excellent opportunity in a large multispecialty group for a board certified physician in family practice or internal medicine. This leadership opportunity is based in a northern Twin Cities suburb and requires 50 percent administrative time and 50 percent clinical care. The practice is part of a large integrated health care system and offers a competitive salary and benefits along with a generous call schedule. For confidential inquiry, please contact Jolayne Fisher, Allina Health System, 612/992-2361 or 800/248-4921, or fax 612/992-3828. 3-3/97

Hennepin Faculty Associates, Department of Laboratory Medicine and Pathology, is seeking two staff pathologists for the following services: surgical pathology, cytology hematopathology, and autopsy pathology. Applicants should have an academic orientation with research and/or teaching experience. Hennepin County Medical Center is a large metropolitan hospital affiliated with the University of Minnesota. Teaching and supervision of residents in an independent pathology residency program will be a major

Join a medical group rich in support in an area rich in natural beauty.

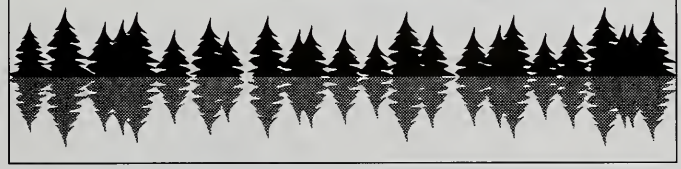
Duluth Clinic, a 300-physician multispecialty group, with 22 regional centers, and serving a regional referral population of 460,000, seeks to add physicians in the following areas:

EP Cardiology	Neurology
Dermatology	Neurosurgery
Emergency Medicine	Orthopedic Surgery
Family Practice	Pediatrics
Internal Medicine	Psychiatry
Nephrology	Radiology

We offer professional autonomy combined with excellent fringe benefits and generous vacation/CME time. If a quality lifestyle is important, this is your opportunity.

Please contact Mike Griffin or Marci Jackson, SMDC, 400 E. 3rd St., #40, Duluth, MN 55805 or call 1-800-342-1388 or fax 218-722-9952
or e-mail to: sr@smdc.org

SMDC
St. Mary's/Duluth Clinic Health System eoe





ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 29-physician multispecialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- PEDIATRICS
- NEUROLOGY
- ONCOLOGY
- INTERNAL MEDICINE/PULMONOLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142

E-Mail: stephanie.l.jussila@qm.healthpartners.com



Central Minnesota Group Health Plan
HealthPartners
1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220

responsibility. The successful candidate will hold an academic faculty appointment without salary in the department of laboratory medicine and pathology at the University of Minnesota. Requirements are M.D., BC or BE in anatomic and/or clinical pathology. Interested applicants should submit current curriculum vitae to: John Crosson, M.D., Department of Pathology (812), Hennepin County Medical Center, 701 Park Avenue, Minneapolis, MN 55415, by March 31, 1997. Hennepin Faculty Associates and the University of Minnesota are equal opportunity educators and employers. 1-3/97

Medical Director: A health insurance organization in North Dakota is seeking a medical director to share the responsibility for the overall development and maintenance of the medical management program within the state of North Dakota. Qualifications for this position are: MD degree and residency completed in a recognized specialty, proven track record of successful medical management leadership within a managed care environment, demonstrated ability to work effectively with groups, understanding of quality improvement philosophies, excellent communication skills for facilitating issues to collaborative resolution, and the ability to work effectively as a team member within a managed care organization. For prompt consideration, please complete an application at Job Service North Dakota, 1350 32nd Street SW, Fargo, ND 58103; 701/239-7358 or 800/438-2514. Human Resources, 4510 13th Avenue SW, Fargo, ND 58121; 701/282-1864. An equal opportunity/affirmative action employer. 1-3/97

FAMILY PRACTITIONERS

Gundersen Clinic, Ltd., is seeking two BC/BE Family Practitioners to join our practice in the picturesque hills of northeast Iowa. West Union is part of Gundersen's regional rural network, a system staffed primarily with Family Physicians. The regional network is supported by both on-site and immediate phone consultative services (Medlink) from the 300-plus multi-specialty physician group in La Crosse, Wisconsin.

The West Union practice includes six community clinics, with the hospital and main practice located in West Union. The practice currently includes five Physicians (including a General Surgeon) and four Physician Assistants. Obstetric practice is highly desirable. Call is 1:4. Gundersen Clinic offers competitive salaries and excellent fringe benefits.

If you are looking for a practice that has all the positives of rural life, coupled with the strengths and support of a large multi-specialty teaching institution, please send letter of application and Curriculum Vitae to Frank Perez-Guerra, Manager, Recruitment, Retention and Resource Planning, Gundersen Clinic, Ltd., 1836 South Avenue, La Crosse, Wisconsin 54601; or call 1-800-362-9567, extension 6325.

Gundersen Lutheran

Care for the way you live.

Equal Opportunity Employer

MARCH 1997 INDEX TO ADVERTISERS

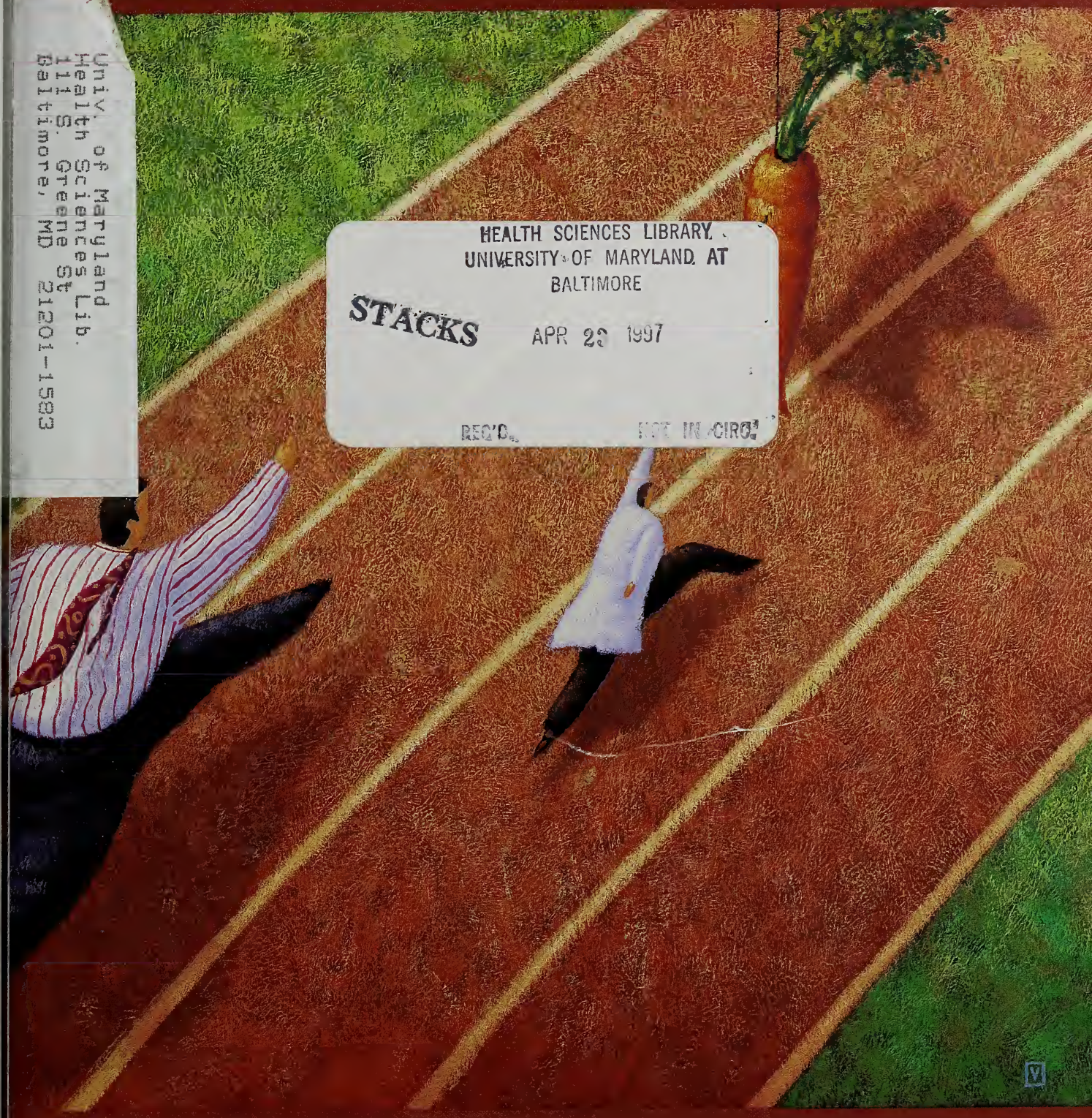
Acute Care Inc. 46
Affiliated Community Medical Centers 46
Air Force Health Professionals–Ft. Snelling 31
Alexandria Clinic, P.A. 63
Allina 5
Aspen Medical Group 51
Brainerd Medical Center 46, 59
Cascade Lodge 48
Central Minnesota Group Health Plan 63
Chisago Health Services 62
Consumer Quote USA 32
St. Mary's/Duluth Clinic Health System 63
Fairview Clinic Services 53
First Call Physicians, Inc. 48
Gundersen Clinic, Ltd. 64
HealthEast–Bethesda 17
HealthEast Capitol Medical Laboratory 29
HealthPartners 58
Hennepin County Medical Center 18
Hennepin Medical Society 8
Lakeside Clinic 56
Mayo Foundation 23
Medical Protective Company 9
Minnesota Center for Rural Health 56
Minnesota Clinic 62
Mitchell Clinic 60
MMBR ..... 41, 42, 49, Covers 3, 4
Multicare Associates of the Twin Cities 29
Navy Recruiting District 59
St. Cloud Medical Group 51
St. Paul-Ramsey CME 3
Staff Care, Inc. 62
Stillwater Medical Group 60
Stutzman-Helling 23
THC Minneapolis 5
U of M Center for Biomedical Ethics 23
U.S. West Communication ..... Cover 2
Wenatchee Valley Clinic 52
Whitesell Medical Locums, Ltd. 52

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

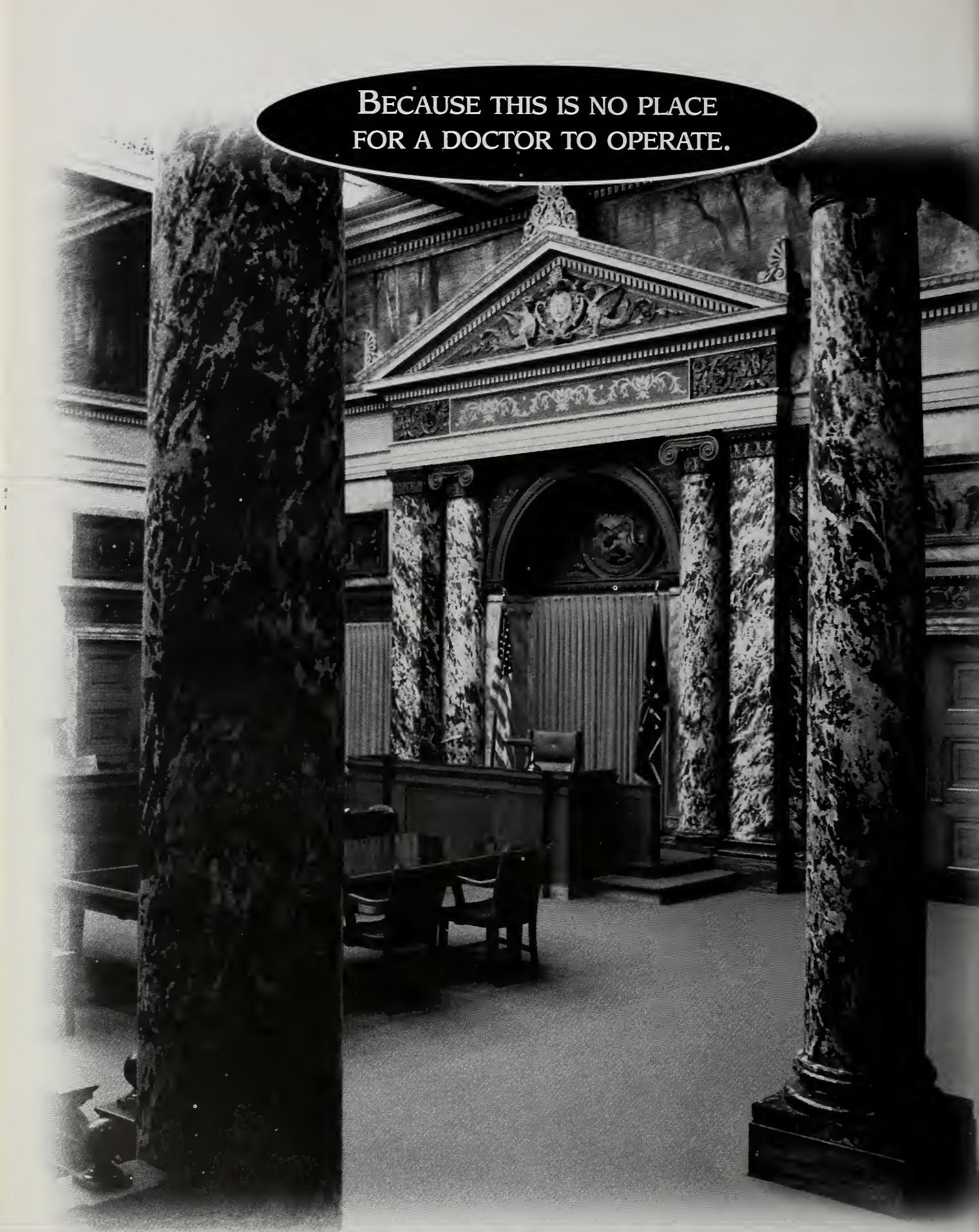
Univ. of Maryland
Health Sciences Lib.
111 S. Greene St.
Baltimore, MD 21201-1583

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE
STACKS APR 23 1997
REC'D. NOT IN CIRC.



Could For-Profit HMOs Give Nonprofits a RUN FOR THEIR MONEY?

APRIL 1997



THE
MEDICAL PROTECTIVE COMPANY ®

Professional Protection Exclusively since 1899

To reach your local office, call 800-344-1899.

GOLD CORPORATE AFFILIATE
MGMA
FOUNDED 1926
PROGRAM UNDERWRITER

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Paul Vismara.

DEPARTMENTS

2 ..... Editor's Notebook

6 ..... Letters to the Editor

58 .... News Clips

63 .... CME in Minnesota

65 .... Classified Ads

68 .... Index to Advertisers

FACE TO FACE

8 **Uniting Business and Medicine** ..... Charles R. Meyer, M.D.
William W. McGuire, M.D., runs the multibillion-dollar United HealthCare Corp. by combining business savvy and sound medical principles.

PERSPECTIVES

12 **Urban Medicine** ..... Colleen Townsend
A fourth-year medical student reflects on the challenges of providing health care to the disenfranchised.

COVER STORY

14 **Will For-Profit Health Care Give Nonprofits a Run for Their Money?** ..... Allan Baumgarten, J.D.
Legislators worry that for-profit HMOs would pull money out of Minnesota, but is current policy keeping capital and innovation out?

SPECIAL REPORTS

21 **Minnesota: The Land of Nonprofit HMOs** ..... Lynn A. Blewett, Ph.D., and Stella K. Hofrenning, Ph.D.
Should the state open its health care market to for-profit HMOs?

27 **For-Profit and Not-for-Profit Health Care Organizations: An Annotated Bibliography** ..... Robert Koepp, M.A., and Steven H. Miles, M.D.
The articles summarized contrast the behavior and outcomes associated with for-profit and nonprofit health care.

CLINICAL & HEALTH AFFAIRS

42 **Rural Enrollment in MinnesotaCare** ..... Barbara P. Yawn, M.D., M.Sc. and Sarah Krein, R.N., B.S.N.

50 **Thoracoscopic Sympathectomy for Palmar Hyperhidrosis: A Case Report** ..... Patrick C. Graupman, Gaylan L. Rockswold, M.D., and David Blake, M.D.

MEDICINE LAW & POLICY

53 **Officers, Trustees, Directors Beware! IRS-Imposed 'Intermediate' Sanctions Can Be Severe** ..... Thomas J. Doyle, J.D.
Insiders in certain tax-exempt health care organizations can pay steep penalties for IRS-perceived compensation abuses.

33 The Monitor

Highlights ..... *MMA urges lawmakers to reduce 2% tax • MMA report calls for collaboration with advanced practice nurses • Viewpoint: Update on MMA legislative goals*

Should We Take the For-Profit Plunge?

In this spring of disastrous floods in the Ohio River Valley, nobody has noticed the levee encircling Minnesota. This levee holds back not the Mississippi or the Minnesota River but the for-profit medicine flood. The levee is leaking, and how big the leak will be is unclear. For-profit medicine in Minnesota and the other 49 states is this month's *Minnesota Medicine* theme.



"Are not-for-profit health care organizations really proprietaries in tax-exempt clothing?"

Evidence for the flood is compelling. Eighty percent of U.S. nursing homes and 70 percent of HMOs are for-profit. Columbia/HCA, the largest of the proprietary health care firms, owns 319 hospitals and 130 ambulatory surgery centers and generated $17 billion in revenue in 1995. Not-for-profit (NFP) HMOs and hospitals are converting to FP at a vertiginous pace.

The floodwater is not viewed by all as a benign bath. Stories of ill but uninsured waifs turned away from FP emergency rooms by profiteering administrators feed "60 Minutes" exposés. The Volunteer Trustees of Not-for-Profit Hospitals has launched a campaign to educate NFP hospitals about the hazards of FP raids, including secret agreements and unmet financial promises. For-profit CEO compensation rivaling Michael Jordan's provokes cries of, "Who are these companies serving?"

But is FP medicine really different, or are NFP health care organizations really proprietaries in tax-exempt clothing? The debate centers on who runs the organization, who the organization serves, and how well it delivers health care. FPs answer to stockholders and the market; NFPs must have community board representation. FPs can wander the country looking for profitable markets, and they have few statutory obligations to underserved populations; NFPs usually are bound by geography and by law must provide some uncompensated care. With profit uppermost, FPs might slight quality care; NFPs must have quality assurance and consumer complaint systems.

Yet the distinctions are murky. As noted in our cover story (page 14), NFPs make tidy profits, have for-profits subsidiaries, and have tight financial ties with for-profit "service" companies. Debates about community benefit can sound like unwinnable spitting contests: "My foundation is bigger than yours." The annotated bibliography of for-profits outcomes research (page 27) reveals equivocal differences in quality and service between FPs and NFPs.

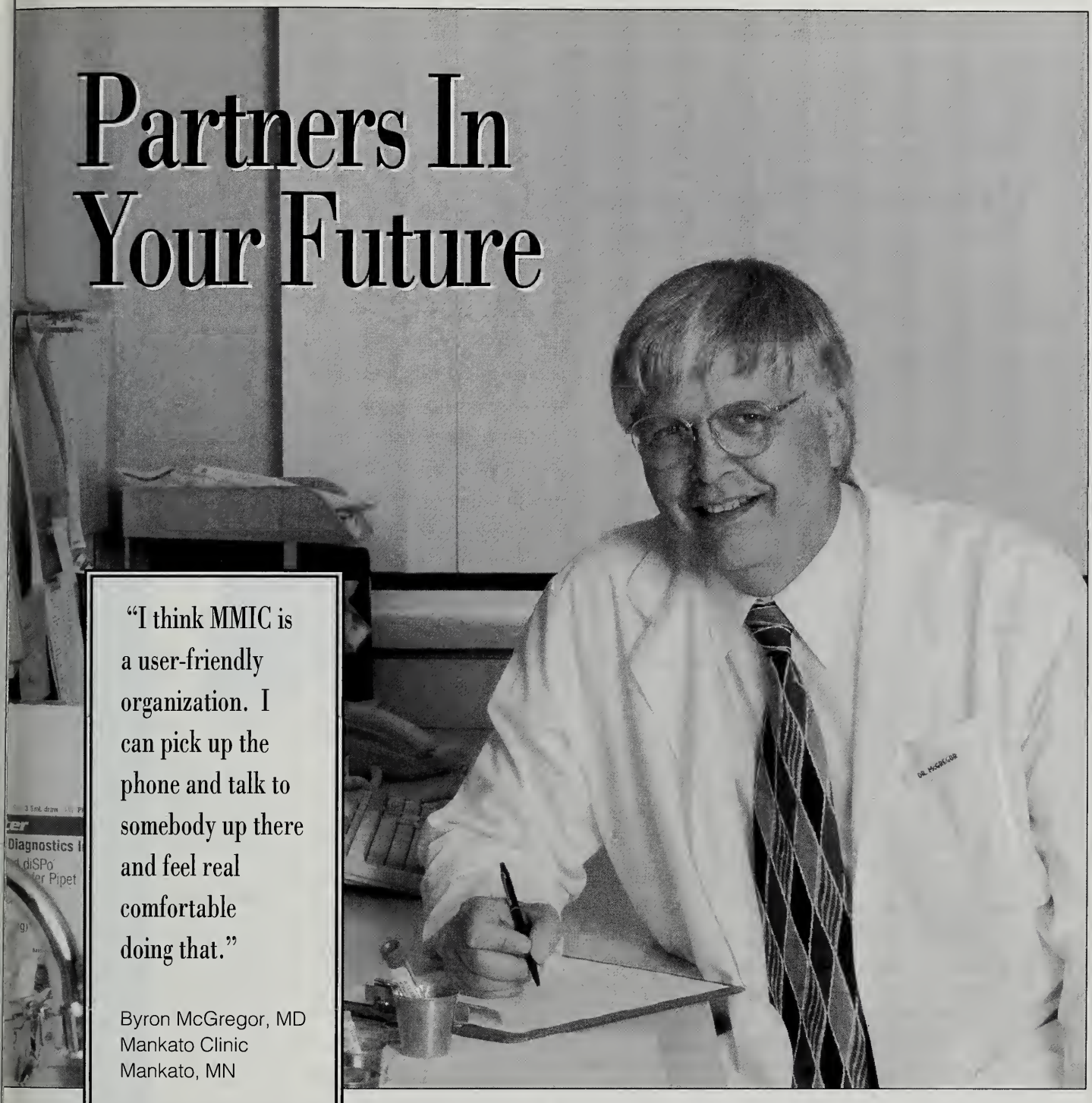
One measure of health care organization quality where NFPs consistently outdistance FPs is the percentage of revenue going to health care delivery. But this statistic is highly accountant-dependent. As the old joke goes, "How much do you want 2 + 2 to be?"

Minnesotans should not think that the FP/NFP debate is a remote squabble about issues irrelevant to our pristine state. Columbia/HCA owns an ambulatory surgery center in Minneapolis. Many Twin Cities nursing homes are controlled by proprietary firms. Local physician groups are owned or managed by publicly traded companies. One of the largest for-profit companies, United HealthCare (see Face to Face profile, page 8) is based in Minnetonka and has close connections with Allina. Eyeing untaxed millions, legislators each session haggle over the validity of Minnesota HMOs' nonprofit status. The land of the nonprofit HMOs and hospitals may not be a 501(3)c haven forever.

In an early 1980s speech to a medical staff, Carl Platou, then CEO of Fairview Hospitals, warned of the threat of for-profit medicine for the United States and Minnesota. He listed the same litany of strengths and sins described in our articles. His prophesy was premature, but now our levee has let a for-profit trickle through. Minnesota will have to decide how wet it wants to get.

–Charles R. Meyer, M.D., Editor-in-Chief

Partners In Your Future



"I think MMIC is a user-friendly organization. I can pick up the phone and talk to somebody up there and feel real comfortable doing that."

Byron McGregor, MD
Mankato Clinic
Mankato, MN

In today's changing medical environment, physicians need to view their professional liability insurer as an important partner in their future. And what better partner can a physician have than a physician-owned and controlled liability insurer such as Midwest Medical Insurance Company. A company that understands a physician's desire to practice the art of medicine.

As your partner, MMIC is here to assist you in your new working relationships and to develop products and programs which improve patient care and lower liability exposures.

MMIC is here for the long term. We bring to the partnership a financial strength of over $251 million in assets and a total equity of over $104 million. Our rating from A.M. Best is A (EXCELLENT).

For a competitive quotation and other information on services offered by MMIC, please call us at 1-800-328-5532.

MMIC

MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S. Minneapolis, MN 55435-1891

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Consulting Editors
Lenore Franzen
Susan Rodsjo

Assistant Editor
Juliet Ramotar

Graphic Designer
Susan Rodsjo

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine.* The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/DIAL MMA (342-5662).

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff
Mark Vukelich, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine.* Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1996-97 Officers

President
Raymond G. Christensen, M.D.

President-Elect
Kent S. Wilson, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Paul R. Hamann, M.D.

Secretary
Judith F. Shank, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Anthony C. Jaspers, M.D.

Vice Speaker of the House
Blanton Bessinger, M.D.

Past President
Michael J. Murray, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Trinky Pollard

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth Crabb, M.D.
Theodore L. Fritsche, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

Director of Communications
Mark S. Vukelich

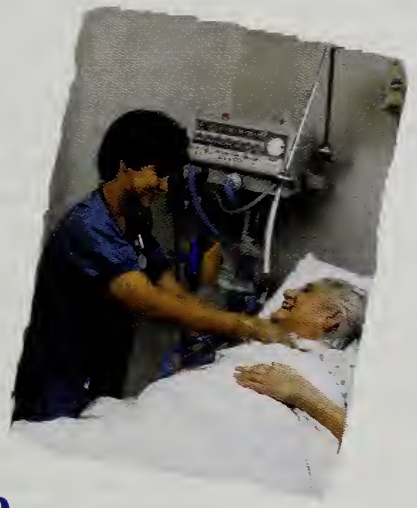
MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875.

E-mail: mma@mnmed.org

Web site: www.mnmed.org

SPECIAL CARE
FOR SPECIAL PATIENTS



Recovery from an illness, accident or injury requires experienced medical professionals, state of the art equipment and technologically advanced therapies. It also requires a comforting, nurturing staff, a "home away from home" environment and family involvement in patient care. Our hospital is dedicated to the recovery of critically ill patients. And we're with you every step of the way, with cost effective care that includes:

- *Pulmonary/Ventilator Program*
- *Wound Care Program*
- *Medically Complex Program*
- *Low Tolerance Rehabilitation Services*
- *Early Cognitive Recovery Program*

THC · Minneapolis...dedicated to returning each patient to the most productive life possible.

THC
Minneapolis
A Subsidiary of Transitional Hospitals Corporation

621-588-2750

CONTINUING MEDICAL EDUCATION

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

APRIL, 1997

4 CARDIOLOGY UPDATE
Presented by: Minneapolis Heart Institute Found.
Location: Doubletree Grand Hotel, Bloomington

15-16 ADVANCED TRAUMA LIFE SUPPORT (ATLS)
Presented by: Allina Health System
Location: United Hospital, St. Paul

19 URODYNAMICS
Presented by: Abbott Northwestern Hospital
Location: Abbott Northwestern Hospital, Minneapolis

MAY, 1997

1 PRINCIPLES OF DIABETES
Presented by: Allina Health System
Location: Mercy Hospital, Coon Rapids

14 HEALTH CARE FOR THE UNDERSERVED
Presented by: United Family Health Center
Location: United Hospital, St. Paul

JUNE, 1997

19 MINIMALLY INVASIVE CARDIAC SURGERY
Presented by: Minneapolis Heart Institute Found.
Location: Hyatt Regency Hotel, Minneapolis

For more information, contact the Allina Office of Clinical Education - (612) 992-2424

™ A Trademark of Allina Health System

Visit the Allina Home Page at http://www.allina.com



An Act of Courage

I commend Steven Miles, M.D., for revealing his bipolar disorder diagnosis, which has unjustifiably interfered with his obtaining relicensure from the Minnesota Board of Medical Practice. (See January *Minnesota Medicine,* page 42.)

Only when more individuals like Dr. Miles refuse to be shamed into silence about their psychiatric diagnoses will society realize that people with these conditions are not much different from everyone else.

Almost all patients whom I evaluate for depression have had concerns about seeking treatment. Sometimes patients waste years of their lives in an effort to avoid acknowledging their psychiatric problem.

I wish Dr. Miles success in his attempt to change the board's policy.

Judith F. Kashtan, M.D.
President
Minnesota Psychiatric Society
Minneapolis, Minnesota

BMP Approach Deters Mental Illness Treatment

I want to express my appreciation for the article "Do State Licensing Procedures Discriminate Against Physicians Using Mental Health Services?" by Steven Miles, M.D., in the January issue of *Minnesota Medicine*. As a physician who has also struggled with the symptoms of depression for years, I have always felt deterred from seeking help by the all-too-clear attitudes of public and professional bodies toward "mental illness." As Dr. Miles suggests, how can one not be deterred by licensing and recredentialing forms that routinely seem to lump treatment for depression into the same category as expulsion from a medical staff, revocation of a DEA license, or conviction of a felony offense ("If you answered yes to any of these questions ... ")?

Although I admire Dr. Miles' honesty in his forthright discussion of his depression, I must take his experiences with the Board of Medical Practice as illustrative. Even though I feel I might benefit personally from medical care for my depression, I am loath to endanger my livelihood or invite the inquisition he has faced by openly seeking the same.

A physician and member
of the MMA
Minneapolis, Minnesota

'Our Stolen Future' Is a Rook

Your January 1997 review of "Our Stolen Future" (Dutton, 1996) is more kind than the book deserves. The authors attempt to link an alleged increase in cancer and drop in human fertility to environmental toxins and their effect on endocrine activity. Unfortunately, the book departs from the scientific method in arriving at its conclusions. Instead of examining a hypothesis by unbiased accumulation of data and reasoning before reaching a conclusion, the authors have already made up their minds, and they search for corroborating data to support their bias.

The alleged increase in human cancers is more apparent than real. The relative increase in cancer is related to a decline in cardiovascular mortality; malignancies in absolute numbers are unchanged since before World War II. A decrease in human fertility is not widely accepted. More likely, the socioeconomic reasons that lead to later childbearing is the major factor; women in their 30s are less fertile than women in their 20s. The epidemic of sexually transmitted reproductive tract infectious disease in women also lowers fertility.

In addition to quoting "numerators without denominators," the authors' translation of animal observations to human disease is fraught with error. Dosages differ, as do thresholds of toxicity and detoxification mechanisms.

Most studies minimize the effect of environmental pollution on human disease. Yet the lay public's perception is that most cancers are caused by pollution. "Our Stolen Future" contributes to this misconception, fueling anxiety and fears and distorting the truth. The most frightening consequence of this misinformation is that the real causes of human disease, the personal pollution within reach of one's hands—tobacco, the high-fat American diet, alcohol abuse, sexual incontinence, and sun worshipping—are not given the attention they deserve. Instead, we are distracted by theoretical concerns that remain unproven and are undoubtedly of little consequence to human beings.

Seymour Handler, M.D.
Pathologist
North Pathology Associates, P.L.L.P.
Robbinsdale, Minnesota

Government, Not War, Is Our Worst Disease

The February Editor's Notebook introduced the journal's major theme for that month: war as a medical problem. Your contention that war is our worst chronic disease is dead wrong. The world's worst chronic disease this century

is another clever scoundrel called government. War is only a by-product, a backdrop.

In war, two political, religious, geographic, economic, or military powers battle with each other. Government may wreak destruction not only on another government but also on its own constituents. A case in point is the murder of nearly 20,000 Arab citizens by the Syrian army in 1982. Mao Zedong of China has been said to be responsible for the deaths of around 20 million people. How many Russians were victims of Joseph Stalin's policies?

As I write this letter, untold thousands are starving to death in Africa and elsewhere. Yet, there is plenty of food available on this planet from generous and willing contributors. We have no famine.

Governments are preventing food from reaching people who are hungry. And what about government-sponsored terrorism? Governments of all nations, including our own, should be recognized as culpable in this ongoing mass murder and maiming.

Ted Papermaster, M.D.
Combat veteran of World War II
Retired pediatrician
St. Louis Park, Minnesota

Great Issue on Spirituality

My congratulations on the December issue of *Minnesota Medicine*. Another excellent issue! The spirituality and medicine theme represents subject matter in which, I sense, physicians have a great interest. Managed care still has not responded to spirituality and its effect on outcomes. You might consider taking a more in-depth look at the book "Timeless Healing," by Herbert Benson, M.D., which was reviewed in the December issue. In his book, Benson mentions improved results in 20 percent to 40 percent of patients whose spiritual needs were considered. I will be interested to see how managed care responds when it gets a hold of this info.

Again, a great issue! Also, a GREAT cover!

Pat Zook, M.D.
Family Physician
St. Cloud, Minnesota

A Call for GPO Members

The Great Plains Organization for perinatal health care (GPO) has been in existence for 26 years. Representing six Midwestern states—Minnesota, South Dakota, North Dakota, Iowa, Kansas, and Nebraska—GPO promotes optimal family-centered perinatal care.

GPO has recently reorganized and changed management and is undertaking a major membership drive. By joining GPO you also join your state perinatal organization, Minnesota Perinatal Organization (MPO). We are changing the annual membership renewal date for all six states to the spring. This change will make it easier for us to send renewal notices and to track membership closely. The GPO annual meeting is May 5-6, 1997, at the Minneapolis Marriott in Bloomington, Minnesota.

To obtain more membership information or to receive the brochure, please call Pathfinder Resources, Inc., at 612/647-6905. We need your commitment to your regional perinatal organization at this time. Thank you for your interest and support.

Virginia Caspersen
President
Great Plains Organization
St. Paul, Minnesota

ASPEN
Medical Group

Family Practice
Full Time Urgent Care

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

IT'S TIME WE CLEAR THE AIR...TOGETHER.

SMOKE FREE 2000

COALITION

For more information please call 612-338-8193.

Uniting Business & Medicine

By Charles R. Meyer, M.D.

William W. McGuire, M.D., runs the multi-billion-dollar United HealthCare Corp. by combining business savvy and sound medical principles.

William McGuire knows the chemistries of both clotting and consolidation. Before embarking on a business career that led him to his present position as chair, president, and CEO of United HealthCare, McGuire pursued a medical career that took him to the Scripps Institute in La Jolla, California, where he authored numerous papers on the role of the Hageman factor in pulmonary inflammation. His pathway from laboratory to board room took remarkably few intermediate steps, a road of elegant simplicity that any biochemist would envy. Today, McGuire directs the $12 billion health care giant from UHC headquarters in Minnetonka.

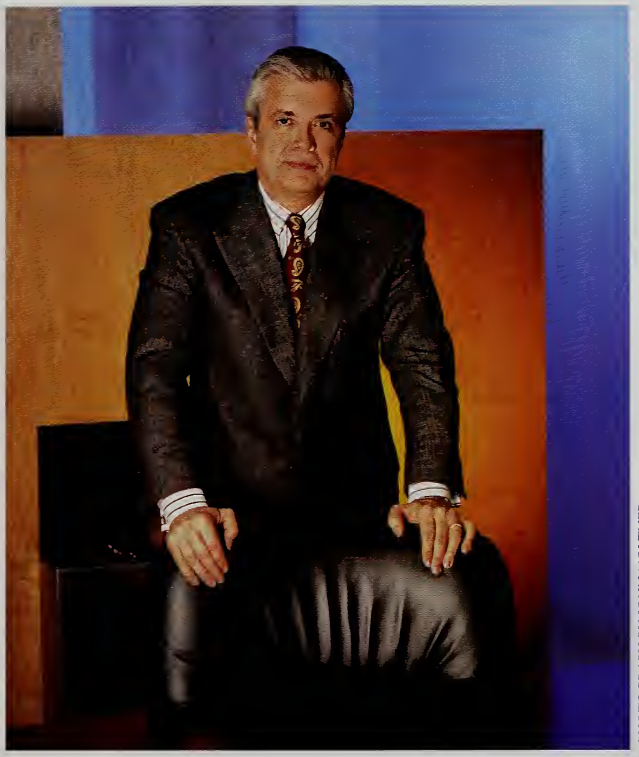
At the Epicenter

The lobby to UHC's executive suites is classic corporate. Large, glass buzz-me-in doors open into a spacious room dominated by a single receptionist at a central desk. Anonymous doors on either side lead to the offices. The formality is broken when McGuire approaches with an easy stride and the receptionist greets him as "Bill."

McGuire, an informal and congenial leader of one of the nation's largest health care companies, is also a physician and considers physicians the "epicenter" of the health care system. He graduated from the University of Texas Medical School in 1974, then did an internal medicine residency and pulmonary fellowship at the University of Texas–San Antonio, before moving to Scripps. By then, he had chosen an academic path. "At that point, I was focused on academic medicine and believed very strongly in clinical research, clinical applications of research, and teaching," he says.

McGuire started applying the clinical precepts of pulmonary inflammation when he became head of the cardiopulmonary department at St. Francis Hospital in Colorado Springs in 1980. For five years, he was lead physician in the intensive care unit there. "I treated lots of trauma and intensive care problems. Those years were challenging, but I loved taking care of the patients and, thus, never felt like I was working hard," McGuire says. "They were very rewarding years, but by 1985, I needed something new."

That "something new" was Peak Health Care, a staff-model HMO where McGuire consulted, then became chief medical officer. At Peak, one of the main themes of McGuire's business career surfaced: improving patient access to health care. As a "closed-panel" HMO, the health plan needed to expand its scope, and McGuire was initially hired to broaden patients' access to other doctors. He carried



PHOTOGRAPH BY JOHN NOLTNER

that message to Minneapolis, and today, most UHC health plans are noncapitated, open-access models, roughly following the Medica template.

"We should use the term 'gateway,' rather than 'gatekeeper,' " says McGuire, explaining UHC's approach. "We want people to find the right care at the right time. To get the consumer to use the doctor who is best for them. This leads us to promote programs that offer direct access to both specialists and primary care physicians in our health plans, and to minimize primary care capitation in many, as well."

That and other details about UHC may surprise Minnesota physicians who remember the Richard Burke/PHP debacle, who follow UHC's stock market gyrations, or who associate the company with other for-profit Goliaths, like Columbia/HCA (see sidebar, page 10, for a chronology of United HealthCare). Although UHC at one time employed all of Medica's staff, currently it only provides information and billing services to Medica. Unlike Columbia and other for-profits, UHC does not own hospitals. "We've tried to avoid owning bricks and mortar," says McGuire. "This is not our core capability. It may conflict with principles of choice and access, which we think are important." Unlike many proprietary firms, UHC is not an HMO company but a health care services company whose objective is to serve the patient.

UHC's Mission

UHC's mission is to improve the health and well-being of individuals. McGuire echoes this when he charts the changes in UHC since he arrived in 1988 as executive vice president. UHC has added consumer services, specialty programs in transplant, geriatrics, and behavioral health while adding corporate heft through mergers and acquisitions.

Confronting a health care system he describes as increasingly fragmented, McGuire wants UHC to offer guidance, information, and prevention to consumers. To provide consumers with what McGuire calls "roadmaps," UHC has established Optum Nurseline, a phone line patients can call for information on hundreds of medical problems and broader problems such as family and legal issues. UHC's mammoth information resources also support the drive to improve such preventive health measures as immunization and mammogram rates. "We can head off a lot of disease if we address problems sooner," says McGuire.

Mergers and acquisitions have been the stepping-stones for McGuire's career. He moved from Peak to UHC after Lincoln National Life Insurance Company and UHC jointly purchased Peak. When UHC subsequently divested Peak, McGuire left to join UHC.

Since 1990, UHC has swallowed up company

United HealthCare History

1974—Charter Med, the predecessor of United HealthCare, is formed to manage newly created Physicians Health Plan.

1975—PHP Minnesota, Charter Med's first client, is founded.

1977—Charter Med becomes United HealthCare Corp.

1984—Operating 11 HMOs in 12 states, expanded UHC goes public, trading as over-the-counter stock.

1985—UHC acquires Share Development Corp., an Indiana-based multistate HMO, increasing its plan to 822,400 members.

1986—UHC acquires a majority interest in Colorado-based Peak Health Care Inc., a four-state HMO network with 104,000 enrollees. By year end, UHC covers 1.6 million people and has doubled its 1985 earnings to $7.2 million.

1987—Kennett Simmons, former president of Peak Health Care, becomes UHC's chief executive officer, replacing Richard Burke. UHC experiences $15.8 million loss; stock drops from $15.88 to $4.25. UHC seeks infusion of capital from New York investment group Warburg, Pincus Capital Company, L.P.

1988—UHC completes restructuring, including a change in its relationship to PHP. In September, UHC sells Peak but still ends the year with a $36.7 million deficit.

1989—William McGuire, M.D., is named president. UHC boosts earnings to $13.6 million by building specialty companies and launching an aggressive expansion and acquisition plan.

1990—UHC makes a secondary public offering of 3 million shares and uses the additional $100 million to acquire Milwaukee-based Prime Care Health Plan Inc. (103,000 members). UHC posts earnings of $33.9 million on revenues of $605 million.

1991—McGuire is named chairman and CEO. UHC acquires Institute of Human Resources, a network of employee counselors for mental health and drug abuse. In July, two of UHC's managed Minnesota companies—PHP and Share Health Plan—merge to form Medica, serving 480,000 members. That same month, UHC purchases Samaritan HealthPlan, a Wauwautosa, Wisconsin, hospital-sponsored HMO, and merges it into Prime Care. UHC also acquires Ocean State Physicians Health Plan, a Rhode Island HMO. The year's net income reaches $74.8 million.

1992—UHC acquires Physicians Health Plan of Ohio (154,000 members). UHC makes another secondary public offering, generating $200 million, then acquires HealthPro, Inc., a Massachusetts utilization management company. Year-end earnings swell to $111.5 million.

1993—UHC acquires Western Ohio Health Care Corporation (185,000 members), giving UHC 20 percent of Ohio's HMO enrollment. UHC buys HMO America (300,000 members), a Chicago HMO, and merges it with UHC's Share Illinois. UHC sells a Des Moines-based HMO.

1994—UHC acquires Complete Health Systems (272,000 members), and Ramsay-HMO Inc. (177,000 members). UHC sells Diversified Pharmaceutical to Smith Kline for $2.3 billion in cash.

1995—UHC acquires GenCare Health Systems (230,000 members), Group Sales and Services of Puerto Rico, Inc., (135,000 members), and The MetraHealth Cos. Inc. (10.6 million members).

1996—UHC acquires PHP Inc., of North Carolina (132,000 members), HealthWise of America (144,000 members), and Community Health Network of Louisiana (110,000 members).

Source: Excerpted from *International Directory of Company Histories* and *BNS's Managed Care Reporter*, 5 June 1996.

after company—most recently, MetraHealth in 1995 for $1.6 billion. McGuire explains that UHC's merger and acquisition strategy aims to "strengthen markets we are already in, build new growth platforms for future business, and gain skill sets that we don't already have." Adding 10 million Americans to the 30 million people already served by UHC, MetraHealth offered a platform and health care products that launched UHC into the world of Fortune 500 companies. It will allow UHC to offer its managed care products to the large base of MetraHealth customers who have traditionally participated in indemnity-type programs.

Broadening its network also enables UHC to make Medicare managed care more portable through 20 urban centers in a program built on reciprocity among plans. Like health clubs offering cross-privileges, UHC allows seniors in its various plans to get health care in cities away from home. "We think we can make things better for seniors," McGuire says. UHC also recently signed a contract with the American Association of Retired Persons, the nation's largest organization for seniors, to deliver a Medigap product and design a complement of new health care products beginning in 1998.

The Bottom Line

Not everybody believes for-profit health care companies focus on making things better. Charges of patients before profits have sparked consumer and legislative reactions. State legislatures have mandated coverage for procedures and outlawed "gag clauses." Consumer groups like COACT contend that patient care suffers under managed care.

When asked about allegations that for-profit health care companies worship the bottom line at the expense of quality, McGuire responds, "There is no evidence that quality is better in not-for-profit than for-profit companies." Rather, he says, the problems inherent in either approach stem from a dysfunctional health care delivery system. "We can't escape the fact that the health care system got itself into trouble. We know that we have a percentage of procedures that are unnecessary."

The solution, McGuire adds, "lies in assuring the appropriate use of necessary services, eliminating the inappropriate use of unnecessary services, and improving communication of necessary health information."

McGuire describes legislative attempts to ban gag clauses or mandate procedures as micromanagement. "We should no more legislate that people must stay in the hospital than that they should be discharged." Instead, McGuire would like the dialogue to address what we want as a society. "We've never defined essential basic health care and assured people access regardless of their socioeconomic status," he says.

Is Bill McGuire a physician or a businessman? No doubt the bottom line is important to him. Certainly, UHC's growth and profitability under his steerage bespeak his business savvy. But McGuire sounds like a doctor when he describes his vision for the future. "Ultimately, the best health care system for the United States will be founded on sound principles of medicine with an underpinning of economic principle—not an economic principle that we somehow try to fit our medical system into."

It's a long leap from a Colorado Springs intensive care unit to Bill McGuire's polished Minnetonka office. The biochemistry books and stethoscopes are gone, but McGuire has found that his medical training continues to serve him well. "It gives me a compass, a guide to right and wrong." MM

Charles Meyer is an internist with Consultants–Internal Medicine in Minneapolis and editor-in-chief of Minnesota Medicine.

STUTZMAN-HELLING COMPANY
*Your Business & Tax Ally*sm
CONSULTANTS, ACCOUNTING AND TAX ADVISORS
APPRAISALS ARE OUR SPECIALTY
612-546-6375

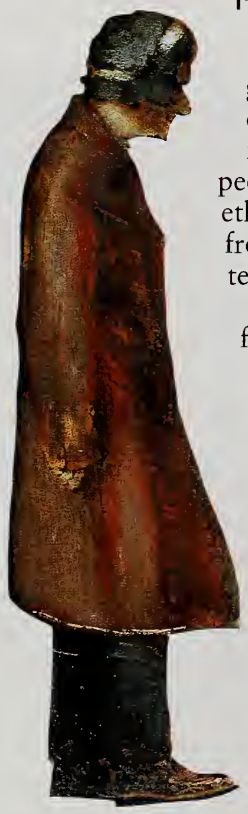
urban medicine

A fourth-year medical student reflects on the challenges of providing health care to the disenfranchised.

by colleen townsend

An assortment of people congregate outside the main entrance to the Dorothy Day Center in St. Paul. Several men cluster near an ashtray by the door, talking and rubbing their bare hands together. Most of them raise their eyes in greeting, a few nod their heads or say "Hi, Doc," as Tim Rumsey, my preceptor, and I, then a third-year medical student, enter the brown brick building.

Odors of infrequently bathed bodies, stale tobacco, and coffee mingle in the warm air. My



gaze takes in the entire community room. Most of the people I see are of ethnic backgrounds different from my own. They wear tattered clothing and worn shoes.

As Dr. Rumsey and I head for the Main Street Health Clinic—tucked in the far corner of the gymnasium-size room—I am aware of the disparity of circumstances that set us apart from the people around us. The privileges of my background, rich in education and social stability, have led me here. Poverty, illiteracy, psychiatric illness, and abuse bring most of the visitors to the center. I choose to work here to further my medical education. The homeless and poor come here out of necessity.

The Dorothy Day Center (DDC) offers daytime shelter, hot meals, and a multitude of social services to people who are homeless, poor, and indigent. Many of the center's services meet its clientele's basic needs. Others provide tools that enable people to progress toward a more mainstreamed lifestyle.

The clinic, housed at DDC, offers both. Operated by the Healthcare for the Homeless Project, it provides free care for the uninsured. The clinic's staff includes medical doctors, chiropractors, psychiatrists, chemical dependency counselors, and physical therapists. It also employs several public health nurses familiar with the social service system. A pharmacist dispenses medications the project provides. Through the collaborative efforts of a dedicated professional staff, an otherwise medically and socially marginalized population receives quality and comprehensive health care. The clinic has given me experience in the practice of urban medicine and shown me the ramifications of limited resources on individuals and health care in our urban communities.

Today's list of patients is long because we are near the end of the month, before welfare and disability checks arrive. I have been coming to the clinic two half days each week for several weeks as part of the elective rotation "Urban Community Ambulatory Medicine," and I recognize many of the faces. As in other clinical rotations, I perform histories and physicals. But the standard history-taking questions are not enough for me to assess the patients I see at the Main Street clinic. To that list of questions I have added:

- Where do you sleep at night?
- How long can you stay here, and is it safe?



ILLUSTRATION BY JOSEPH DANIEL FIEDLER

• Have you ever had a problem with drugs or alcohol?
• Are you currently using drugs or alcohol?
• Have you ever been or are you currently a victim of physical or sexual abuse?
• Do you have a history of psychiatric illness?
• Are you currently employed? If not, when were you last employed?

After I develop an assessment, I review the plan for the patient's care with the staff physician. In addition to these typical medical student "duties," I often proceed, under the guidance of the pharmacist, to dispense the prescribed medication.

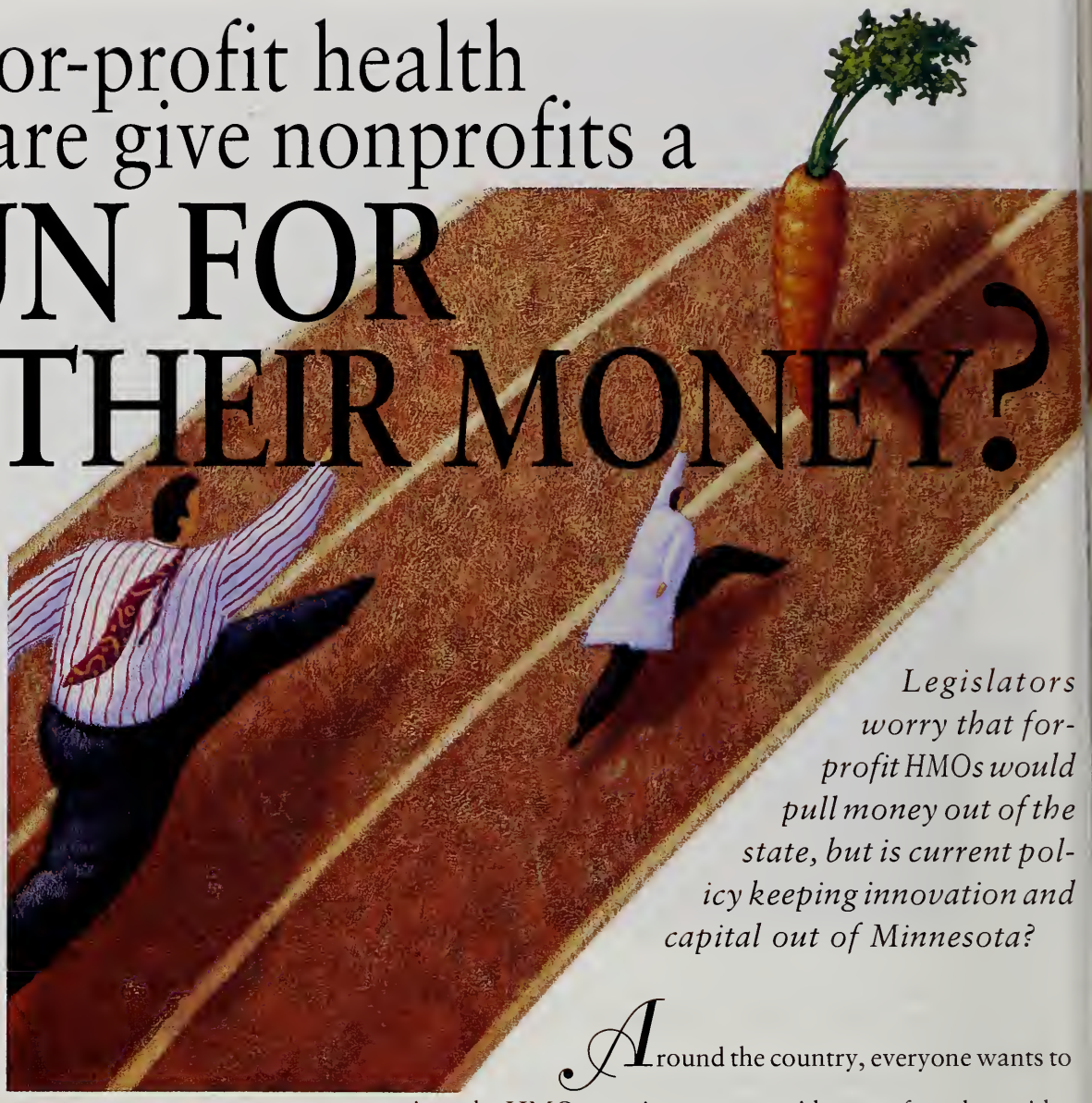
Following are excerpts from a few of the journal entries I have written during my rotation.

I.M., A MIDDLE-AGED HISPANIC migrant worker, complains of burning, itching feet. The soles of his worn shoes provide little protection from moisture or cold. I examine his feet, which show classic signs of tinnea pedis. Thanks to donated supplies, I am able to offer him several pairs of new socks. I also give him a bottle of antifungal powder and a lesson on foot hygiene. These simple interventions allow I.M. to maintain his health ... and his dignity.

K.L., IN HIS MID-20s, is my last patient Thursday evening. He says he wants to quit drinking and using drugs, but he's had difficulty staying clean. K.L. ran away from his reportedly oppressive adop-

URBAN MEDICINE continued on page 57

Will for-profit health care give nonprofits a RUN FOR THEIR MONEY?



Legislators worry that for-profit HMOs would pull money out of the state, but is current policy keeping innovation and capital out of Minnesota?

By Allan Baumgarten, J.D.

Around the country, everyone wants to get into the HMO act—insurers, providers, preferred provider organizations, and even employers. HMOs are popping up everywhere, it seems, except in Minnesota—the state sometimes described as the birthplace of the modern HMO.

Nearly 100 new HMOs formed nationwide in 1995 and 1996. Colorado alone licensed seven new HMOs during this two-year period. Yet with perhaps one exception—the Preferred One Community Integrated Service Network—Minnesota has been reluctant to join the trend. Why? Has the for-profit face of the new HMOs made us suddenly shy to compete? This article

looks at the HMO scene in Minnesota and questions whether state laws regulating these organizations should change.

The Freshman Class of HMOs

Perhaps Minnesota has been reluctant to welcome the new class of HMOs because their profile looks so different from the HMO model Minnesota helped design. Many have been sponsored by hospital-led provider systems, not physicians. Quite a few were formed to contract with states enrolling Medicaid recipients into HMOs and other managed care arrangements. And, perhaps the hardest for Minnesota to swallow, 80 percent of the new HMOs are for-profit corporations.



ILLUSTRATIONS BY PAUL VISMARA

Capitol Community Health Plan (CCHP) in Washington, D.C., and Health Right in Connecticut are typical of the new freshman class of HMOs—for-profit, provider-governed organizations responding to a business opportunity in markets where HMO activity is increasing. Each has its own history.

CCHP was formed in 1996 by five nonprofit hospitals in Washington, D.C., to contract with the District to serve Medicaid recipients. The hospitals' religious, academic, and community ties reflect a commitment to carrying out a shared nonprofit mission, namely, serving low-income families. With 23 percent of the population of the District uninsured and 26 percent enrolled in Medicaid, an enormous need exists for organizations to serve those families. The District plans to introduce a mandatory HMO enrollment program for AFDC recipients later this year. Through CCHP, the five hospitals hope to better integrate with primary care while protecting their market share, estimated to be 70 percent of Medicaid admissions. The HMO began enrollment in late 1996 and had 4,500 members by February 1, 1997. It is competing to be one of four HMOs the District selects to receive contracts under the mandatory program.

Health Right was formed by two federally qualified community health centers in Connecticut in anticipation of the state's move to enroll all AFDC recipients into Medicaid HMO plans. It sought to protect access to Medicaid patients for the health centers and other traditional providers, since large health plans such as Kaiser Permanente and Blue Cross Blue Shield of Connecticut were contracting with the state to enroll Medicaid recipients. Health Right has proven to be a popular plan option, enrolling 28,203 members as of March 1997.

CCHP and Health Right, both for-profits, used different approaches for raising capital. CCHP raised its capital internally but chose to rent administrative services from a Maryland HMO, which Minnesota-based United HealthCare has since acquired. Health Right went to the venture capital markets and raised $4 million in exchange for 49 percent of the company.

Why did these mission-driven organizations form for-profit HMOs? Basically, because they believe that mission and corporate structure are separate issues, and that a community-oriented enterprise should select the corporate structure that best serves its purposes. A for-profit entity has several advantages: better access to capital, including venture capital and public offerings of stock; better compensation and pension options for staff; and opportunities for economies of scale in their operations. For-profit companies can raise capital by selling shares of the equity in the firm. Nonprofits cannot sell equity shares and can only raise capital through various debt instruments. Investors in that debt are typically allowed favorable, tax-exempt treatment on the return, which, in effect, provides a public subsidy.

Minnesota's HMO Law

Minnesota is the only state that does not allow an organization to form a for-profit HMO. It makes no difference whether the organization is the most capitalistic managed care corporation or the most community-oriented provider in the state. For-profit HMOs were

barred with the enactment of Minnesota's HMO Act in 1973. At that time, proponents of the legislation argued, among other things, that keeping the profit motive out of the picture would limit the possibility that HMOs would reduce care to save money. Other HMO regulations reflected that concern, including requiring 40 percent consumer membership on boards and having quality assurance and consumer complaint systems. Although Minnesota had a hand in creating the HMO, some state leaders seem determined to prevent what might be seen as a natural evolution of the concept.



That doesn't mean that Minnesota HMOs don't have close connections to for-profit entities. Several HMOs contract with for-profit management companies to provide some, and in a few cases virtually all, administrative services. For example, Medica contracts with United HealthCare for administrative services, and HealthPartners buys some services from Aetna/US Healthcare. When the Mayo Foundation organized its HMO in the 1980s, it created its own for-profit management company to administer the HMO. These arrangements must pass muster with state regulators so that fees paid are not deemed unreasonable.

Similarly, all of the major health plan companies in the state also have significant for-profit subsidiaries or operations. Medica administers self-funded employer health plans through a for-profit subsidiary, and Blue Cross Blue Shield of Minnesota (BCBSM) has created a number of for-profit companies providing services such as pharmaceutical benefit management and electronic data interchange.

What happens in the other 49 states where for-profit HMOs are permitted and are operating? Note that some states, such as Michigan, permit for-profit HMOs, but nonprofit companies such as the Health Alliance Plan (the HMO of the Henry Ford Health System) and Blue Cross Blue Shield continue to be the dominant health plans. With the exception of a United HealthCare HMO, national companies have generally passed over Michigan while entering neighboring state markets in Illinois and Ohio.

Most other states approach HMOs differently. They regulate all HMOs more like insurance companies, unlike in Minnesota, where the Department of Health is the HMO regulator. In other states, the insurance commissioner handles financial oversight, perhaps leaving some quality assurance or access oversight issues to health officials.

Where Will All the Profits Go?

Minnesota legislators are concerned that for-profit HMOs will invest their profits elsewhere, so health care consumers in the state aren't the beneficiaries.

What does happen to the surpluses HMOs earn? Among for-profit national companies, a large chunk goes to the parent company. State regulators review this amount to determine whether "too much" is leaving the state. FHP in Colorado, for example, had a 1995 profit of $21.7 million, after paying $12.9 million in federal income taxes. Most of that amount FHP transferred to its parent company for operations, acquisitions, and dividends to shareholders. Among major Colorado HMOs, FHP maintains the smallest net worth (per member) on its Colorado balance sheet, preferring to manage both assets and liabilities at the corporate level.

Large national companies can also move capital around the country to gain market share, effectively cross-subsidizing startup operations or plans in competitive markets with profits made elsewhere. PacifiCare, for example, moved aggressively into the Northwest with its Medicare products, beating the local HMOs on price.

A nonprofit that is heavily invested in owning clinics and equipment, like Kaiser, applies part of its surpluses to constructing new facilities or replacing equipment. But do nonprofit HMOs make significant contributions to the community? That depends on whom you ask. Nowhere are existing HMOs required to cover uninsured families or to operate clinics that base fees on patients' ability to pay. An HMO like George Washington University Health Plan may provide an enhanced capitation rate to primary care providers to support medical training and research. Yet lawyers practicing in the area believe that the Internal Revenue Service would not grant tax-exempt status to a new HMO whose community benefit was limited to selling health insurance in that market. That may help explain why so few nonprofit HMOs have been formed recently.

In Minnesota and some other states, HMOs are required, implicitly or explicitly, to serve Medicaid and other public assistance recipients as a condition of serving public employees. Medicaid business has been profitable in Minnesota, so it might be harder to argue that HMOs' Medicaid programs provide a community benefit. (Does this mean that an HMO can't benefit the community without losing money in the process?) In some regions, Kaiser and other HMOs open their clinics to serve uninsured children but recover their direct costs through local government payments.

A FINANCIAL MODEL FOR HMO CONVERSIONS

What would the impact be of converting a Minnesota HMO to for-profit status? Let's take a look, using a model proposed by Doug Sherlock, an independent analyst of HMO finances.

An HMO that is bought by another HMO or that sells its assets to the public through a stock offering can expect to receive about $1,000 per member, based on recent transactions. Assuming 200,000 members in the HMO, that creates a value of $200 million. That money would create the corpus of a charitable foundation formed for that purpose. Based on an annual return rate of 5 percent of the corpus, the foundation would make distributions of $5 million a year. That revenue could buy annual insurance coverage for 6,944 uninsured persons, based on $120 per member per month. Or it could improve access to primary care in other ways, such as supporting community-based providers. *–AB*

Some HMOs have chosen to create foundations as vehicles for providing community benefit. In Minnesota, three HMOs—Blue Plus, Medica, and Metropolitan—have designated portions of their surpluses for foundations or other related purposes. Medica created a foundation (now part of the Allina Foundation) and put $3 million into its programs in 1993 and 1994. But those contributions pale when compared with the value of the enterprise. In California, the conversion of Blue Cross's managed care business to a stock company eventually provided more than $3 billion in capital to new foundations.

Nonprofit HMOs, like their investor-owned counterparts, use their surpluses for business development and acquisition. Blue Plus and its parent company have used their surpluses to provide capital for joint ventures with physician groups in several parts of the state. These transfers have occurred two ways—providing capital to start up a jointly owned community integrated service network (CISN) or other entity, and providing capital to the medical group over a period of years in exchange for a covenant not to sell to a competitor. For example, BCBSM made an agreement with the Dakota Clinic in 1994 under which it contributed capital to establish a joint venture CISN and agreed to pay an additional $27 million over 20 years in return for a covenant by the Dakota Clinic physicians not to sell. BCBSM has similar arrangements with Affiliated Medical Centers in Willmar and with the Mankato Clinic.

Through its alliances with the Dakota Clinic and the Mankato Clinic, BCBSM has also secured assurances that it will have sufficient clinic capacity to support anticipated future growth. If there is not enough for

everybody, BCBSM is assured that it can have access to that capacity on a preferential basis. Competing health plans that seek to expand in those areas might be shut out by those systems and will need to make their own arrangements.

Why Not Allow For-Profits?

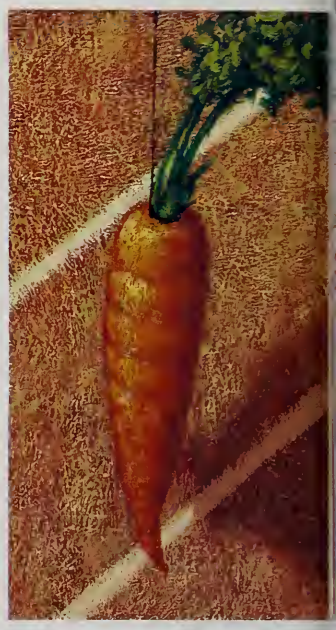
Minnesota legislators have resisted the arguments for allowing for-profit HMOs since the state first passed its HMO act. Each time the issue resurfaces, proponents come in with new arguments. In the past two years, proponents have argued that the state is encouraging market concentration because it bars new competitors. In the Twin Cities area, three companies—Allina, HealthPartners, and BCBSM—control almost 80 percent of the health plan enrollment. Why not allow new competitors if that would address the growing domination of the market by a few companies?

Legislative leaders who oppose for-profit HMOs want more competition but want to determine who the competitors will be. Minnesota organizations that will make themselves available to the state are good, as opposed to national companies that would use the distance between them and St. Paul to avoid local accountability. In fact, some legislators feel that nonprofit entities are more accountable because they have to disclose more information to the public.

To encourage local provider organizations to form new entities, the state made the financial standards for CISNs more flexible. However, only Minnesota nonprofits can apply. The state may have hoped the new CISNs would create new competition, but the results so far have been disappointing.

If given the chance, would for-profit HMOs want to enter the Minnesota market? While national HMOs would be interested in the business opportunity, given Minnesota's relatively high inpatient hospital utilization, a surplus of specialists and hospital beds, and the relatively low rate of uninsurance, they see better opportunities in other markets, particularly in the Northeast.





For-profit HMOs may have the most to offer local entities that haven't had access to necessary capital. Increases in federal Medicare payments in rural areas and the expansion of Medicaid managed care in outstate Minnesota will create opportunities for new HMOs. Whether local providers are interested is not clear. In 1993, the Minnesota Hospital Association and the Minnesota Medical Association strongly supported the state's initiative to create integrated service networks (ISNs) as a new generation of managed care plan. They hoped that providers could reclaim some of the economic power they lost over the years to HMOs. More recently, though, providers seem to have lost interest in forming their own ISNs or HMOs. Instead, they are pursuing options for direct contracting with private and public purchasers, while avoiding requirements to form capitalized and regu-lated organizations.

While legislators worry that for-profit HMOs would pull money out of Minnesota, current policy is keeping money out of the state. The lives covered by an HMO represent a significant asset that has value in the marketplace. Institutional investors and venture capitalists are eager to work with those assets. Under current policy, Minnesota venture capital firms that want to invest in health care delivery and finance systems must look beyond the state's borders.

The sidebar (page 17) suggests a model for converting those assets for public benefit. The same argument can be made for hospital conversions. The equity capital in a nonprofit hospital is used partly for mission purposes and partly for subsidizing payers who should be paying market rates. Converting the hospital to for-profit and its assets into a foundation allows the organization to use all of its equity capital for charitable purposes.

Does the public care if HMOs are required to be nonprofits? Consumers and the broader marketplace do not see a difference between for-profits and nonprofits. When it comes to purchasing decisions, price and access to preferred physicians are more important than the

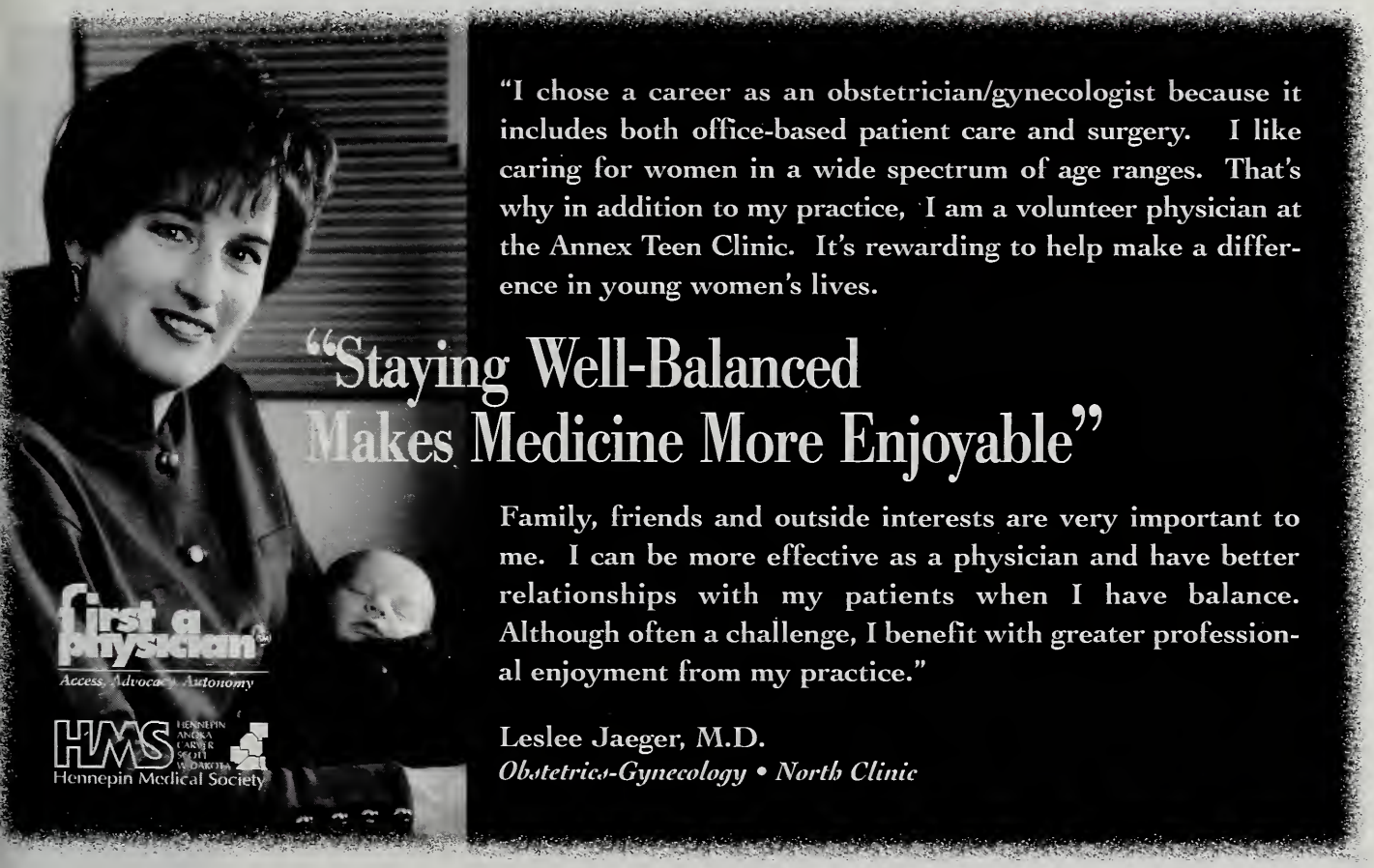
HMO's tax status. Information on the quality of care in HMOs is sketchy, and what we know doesn't demonstrate a difference in quality between for-profit and nonprofit systems (see related annotated bibliography, page 27).

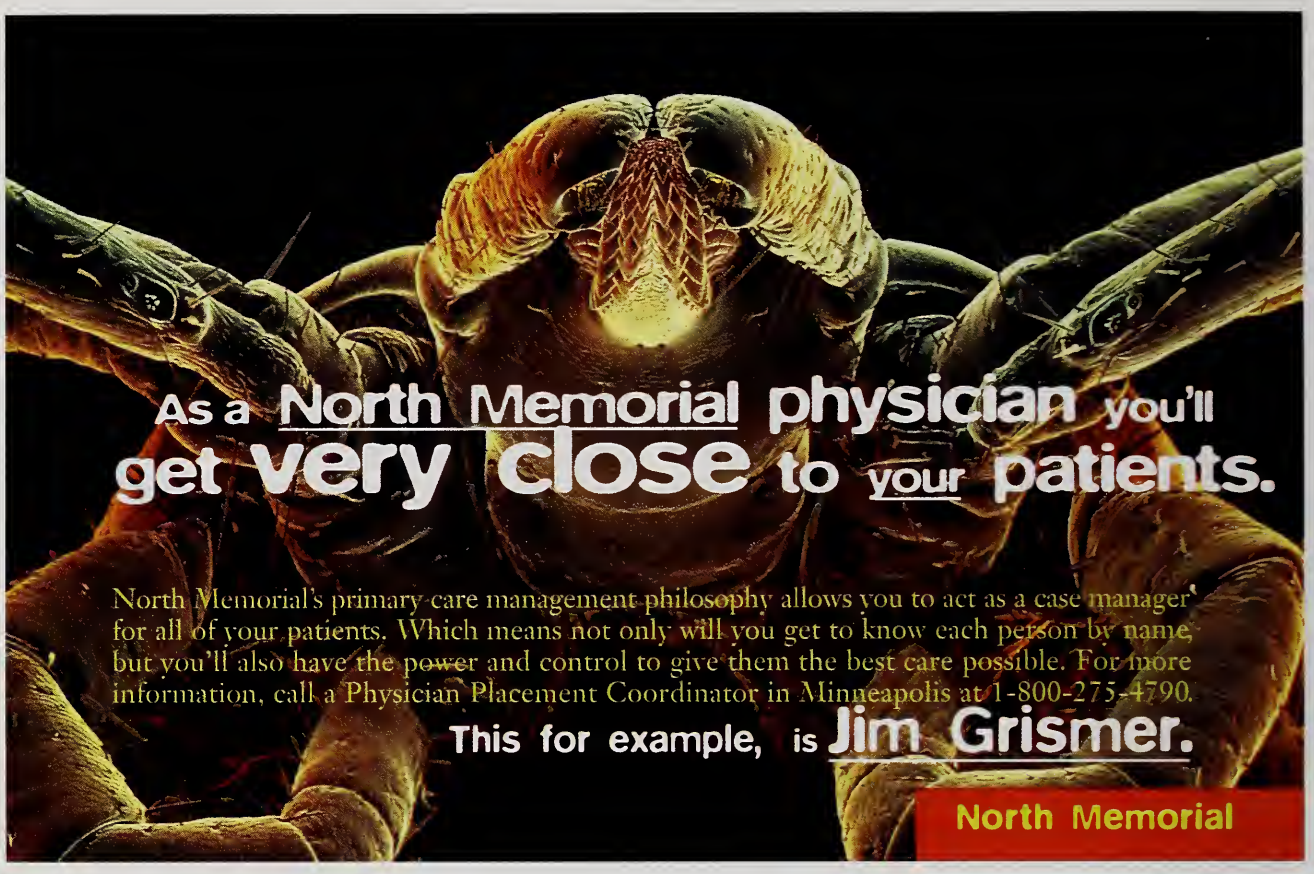
Minnesotans don't seem any more willing to trust their nonprofit HMOs than people in other states. Each year they seek to rein in what they see as the excesses of HMOs, such as short hospital stays for mothers and newborns following normal deliveries. The fact that HMOs are organized as nonprofit corporations offers Minnesotans little reassurance. Neither do they trust that their physician, their employer, or their health plan company will speak on their behalf.

Consider Connecticut's Health Right, a model of the new for-profit HMO. Does anyone believe that it won't be held to a high standard of accountability, both for its financial performance and for the care it provides? Even though Minnesotans didn't create the model, they may find that for-profit HMOs are just what the doctor ordered. MM

Allan Baumgarten is a consultant on health care policy and finance and author of Minnesota Managed Care Review *and* Colorado Managed Care Review, *annual reports analyzing key trends and issues in those markets.*







HealthPartners
St. Paul-Ramsey Medical Center

CME
640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

CONTINUING MEDICAL EDUCATION
1997 SPRING CONFERENCE SCHEDULE

Agricultural Medicine	April 2
Annual Obstetrics & Gynecology Update	April 3-4
Annual ENT Update	April 4
Critical Care 1997	April 17-18
NIOSH-Approved Spirometry	April 28-29

INFORMATION AND REGISTRATION:
Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612-221-3992 • Fax 612-292-4773

St. Paul-Ramsey Medical Center/Ramsey Clinic/Ramsey Foundation are Members of the HealthPartners Family of Health Care Organizations

HealthPartners
RAMSEY

Minnesota: The Land of Nonprofit HMOs

Should the state open its health care market to for-profit HMOs?

Lynn A. Blewett, Ph.D., and Stella K. Hofrenning, Ph.D.

Last fall, the Minnesota Health Care Roundtable sponsored a panel discussion that explored the question, how can 49 states be wrong?[1] Minnesota stands alone in prohibiting for-profit HMOs to operate in the state, a distinction likely to be retained unless a substantial change occurs in the legislative leadership or at the grasssroots level. Despite the many persuasive arguments for introducing for-profit HMOs into the Minnesota market, the Legislature appears tuned in to Minnesotans' aversion to for-profit health care and is not apt to change its position any time soon.

The real question is, what does Minnesota gain from prohibiting for-profit HMOs? Put another way, what would Minnesota lose if for-profit HMOs were allowed? This article discusses possible advantages and disadvantages of allowing for-profit HMOs in Minnesota and considers conversion issues that would result if the state allowed for-profits.

Background

A health maintenance organization (HMO) delivers a stated range of services to a defined enrolled population for a fixed monthly or annual premium and assumes some of the financial risk or gain from providing these services. HMOs were designed to be an alternative to fee-for-service medicine and to deliver services more efficiently. Currently, HMOs provide coverage for more than 20 percent of the national health care market; HMO coverage in some states—California, Maryland, and Oregon—has swelled to 40 percent. In Minnesota, the figure is about 26 percent statewide.*

In response to the federal start-up grants provided through the HMO Act of 1973, HMOs began as nonprofit entities. However, since the early '80s, the federal government has been more supportive of for-profit HMOs. For example, the Tax and Fiscal Responsibility Act of 1982 (TEFRA) enabled Medicare and Medicaid beneficiaries to enroll in either a for-profit or nonprofit HMO. In addition, a 1982 change in federal HMO regulations allows the secretary of the Department of Health and Human Services (DHHS) to "waive all or part of the amount of funds repayable to the Secretary when an HMO converts to for-profit."[2]

Nationally, the conversions of HMOs from nonprofit to for-profit status began in the mid-1980s. By that time, all states except Minnesota had changed their laws to allow HMOs to convert. Conversions occur for a variety of reasons, including the elimination of state laws banning for-profit ownership, the end of federal grants to nonprofit plans, the desire by some physician groups to profit by selling their plans to large national companies, and HMOs' perceived need for access to capital to stimulate growth.[3]

California has been a leader in the trend to convert to for-profit health care. In 1980, nonprofits comprised 84 percent of the California HMO market; by 1994, nonprofits made up less than 35 percent. Nationally, for-profits comprised 70 percent of the HMO market in 1995.[4]

Nonprofit HMOs may be organized in a variety of ways. They may be a cooperative (where profits can be passed through to its members), or a nonprofit, nonstock entity, such as HealthPartners (where income and assets cannot inure to the benefit of private individuals). Nonprofit HMOs need not satisfy demands of equity holders and have greater access to tax-exempt bond issues and donations. However, they are excluded from the equity and venture capital markets and have a more difficult time competing in the debt market.

HMOs in Minnesota

In Minnesota, all HMOs must be organized as nonprofits. State statutes define a nonprofit corporation as one that may not "... be formed for a purpose involving pecuniary gain to its members ... [or] pay dividends or other pecuniary remuneration, directly or indirectly, to its members... ."[5] A nonprofit corporation must also apply to the commissioner of health for a certificate of authority to establish and operate an HMO in this state.[6] In other words, the HMO must be located in Minnesota.

HMOs are not new to Minnesota. Railroad workers in Two Harbors established the first prepaid health plan

*Total HMO enrollment in 1995 was 1.2 million. Source: 1995 Minnesota HMO Annual Statements.

in 1944. Today the state has nine licensed HMOs and four smaller community integrated service networks (CISNs), all organized as nonprofit entities. Although many people consider HMOs a statewide phenomenon, they are largely found in the Twin Cities. Currently, 43 percent of the Twin Cities population is enrolled in an HMO, compared with only 9 percent in surrounding areas.† As stated earlier, about 26 percent of the state is enrolled in an HMO. To stimulate managed care in rural areas, the state has relaxed some requirements for plans with 50,000 members or less. Today, 17,050 Minnesotans are enrolled in CISNs.††

Pros and Cons

Across the country, for-profit HMOs are growing rapidly. In many areas, they have become principal players in the health care delivery system. As they expand, the debate over the role of profit in health care also intensifies. Proponents argue that for-profit HMOs will stimulate competition and lead to a more efficient delivery system. Opponents counter that the profit motive does not belong in health care and leads to lower-quality health care, especially for the poor and disadvantaged. The following sections summarize the arguments for and against for-profit HMOs.

Advantages to permitting for-profit HMOs

The leading arguments for allowing for-profit HMOs are that they are more efficient and better managed, they have access to capital at lower costs, and they can stimulate competition.

For-profits may be more efficient, instill greater cost-consciousness, and operate more cost-effectively. Some advocates argue that for-profit institutions will make the delivery of health care more efficient because they are purportedly able to "generate otherwise unavailable capital through equity financing, to offer more attractive employee incentives and operate with a simpler corporate and administrative structure."[2] When providers share in an organization's profits, they are thought to provide care in a more cost-conscious manner. Although the literature dealing with HMOs is voluminous, few reports provide empirical analysis, and no studies assess the efficiency of for-profits vs. nonprofits. Conceptually, however, there is no reason to believe that for-profits should achieve greater economies of scale than nonprofits.

Profit-making organizations are thought to attract more capable managers, leading to lower administrative costs and other managerial efficiencies. For-profit HMOs may be able to attract better managers because they can offer better employee incentives than nonprofits. For-profits are in a good position to reward management for outstanding achievement through financial incentives. They don't face the prohibitions nonprofits face, and they may establish profit-sharing plans and incentive stock option plans.

Because they can issue stock, investor-owned institutions are thought to have access to capital at lower costs. The ease in generating capital can lead to expanding into new locations and markets. The most compelling force driving nonprofit HMOs to convert to for-profit status is their need to acquire capital to maintain operations and expand into new locations. New HMOs face extensive startup costs, while mature plans grow and acquire more sophisticated plants (such as laboratories) and expanded facilities (such as owned hospitals). According to Leonard Schaeffer, past president of Group Health in Minnesota, "Capital markets are only interested in for-profit entities. It is not our desire to become for-profit that drives us in this direction. It is our determination to compete."[2] Although nonprofit HMOs have obtained capital from the sale of tax-exempt state bonds, many state statutes limit this funding source because they do not consider nonprofit HMOs eligible participants. Therefore, HMOs in need of capital have found the private capital markets attractive and are assuming a for-profit status in order to compete for available funds.

For-profits can stimulate growth and competition. For-profit HMOs will likely play a larger role in the HMO industry as new for-profit entities enter the health care market and as nonprofits convert. Health care officials see these conversions as a trend toward more fierce competition among health care insurers, a means of survival, a way of raising capital, and a response to pressures from government, business, and labor to hold down health care costs.

Disadvantages to permitting for-profit HMOs

The leading arguments against for-profit HMOs are that they may lead to a decrease in the quality of care, they may be less willing to serve the local community and the disadvantaged, and they may not operate efficiently.

The profit-maximizing philosophy may lead to decreases in the quality of care. An ongoing controversy exists concerning the quality of care prepaid plans provide. In addition, the economic incentive driving for-profit HMOs tends to lead them to provide fewer, rather than more, services. Luft, in his review of the HMO literature, states, "One commonly held assumption is that HMOs achieve lower costs by underserving and skimping on quality. There is very little evidence to support this notion. The quality of care in HMOs seems comparable to or somewhat better than the community average."[2] Sparse research examines differences between for-profit and nonprofit HMOs in the quality of care they deliver.

Some critics argue that the shift from nonprofit to for-profit HMOs may divert health care dollars away from direct medical care and toward administrative costs and profits. A recent California study comparing the

†Source: Minnesota Department of Health, Health Economics Program, 1995.

††Preliminary enrollment data as of December 31, 1995. CISNs are not required to submit enrollment data. Source: Minnesota Department of Health, Managed Care Systems, Annual Statements.

percentage of every health care dollar spent on medical care showed that nonprofit HMOs spend up to 96.5 percent of their premiums on direct health care services, while for-profit HMOs spend as little as 70 percent of their premiums on health care.[7]

For-profit HMOs may be less willing to serve the disadvantaged. Some observers question the willingness of for-profit HMOs to serve the disadvantaged. Recent changes in federal and state laws allow Medicare- and Medicaid-eligible elderly and low-income people to receive health care services through HMOs. The Schlesinger data show nonprofits serving a greater percentage of both Medicare- and Medicaid-eligible populations.[2] However, for-profit and nonprofit HMOs enroll only a small percentage of these populations, and only a few plans account for the majority of Medicaid patients. Clearly, more research is needed to answer this question.

It is not clear whether a for-profit HMO will behave efficiently. Future growth of the for-profit sector will depend on its ability to compete on both cost and quality. The Schlesinger data compare costs of for-profits and nonprofits, showing that for-profits cost more.[2] For-profits had a higher cost per inpatient day ($538 vs. $495), higher average total ambulatory cost ($364 vs. $330), and higher average inpatient cost per enrollee ($214 vs. $196). In addition, for-profits averaged higher revenues per enrollee ($695 vs. $654). It is impossible to discern from these data what caused the higher costs (higher utilization; higher capital costs; newer, more expensive facilities; different patient mix; greater use of ancillary services; or inefficient operations). However, such cost comparisons do force a careful evaluation of the consequences of the profit motive and HMOs.

For-profits may be less likely to reflect local norms and serve their local communities. To assume local representation, nonprofits are required to establish a board of directors to monitor the operation of the organization in the interest of the community. In addition, the CEOs of all of Minnesota's HMOs reside in the state, and many actively participate in local community and service groups. Nonprofits may be more likely than for-profits to reflect the various needs and interests of the communities in which they are located.[8]

Nonprofit to For-Profit Conversion

An HMO typically qualifies for tax-exempt nonprofit status as a 501(c)(3) or 501(c)(4) organization. By definition, 501(c)(3) recognizes organizations that serve "charitable" purposes, provides for access to tax-free bonds, and makes gifts to the organization tax-deductible. The 501(c)(4) designation recognizes organizations that operate for the "promotion of social welfare" but whose benefits may not accrue to the entire community. These organizations do not have access to tax-free bonds, and any donations they receive are not considered tax-deductible. Case law does not provide explicit criteria regarding tax-exempt status for HMOs, probably because the managed care industry is relatively young, having emerged in the last 15 to 20 years.[3] Yet, despite the narrow legal differences between the two nonprofit classifications, organizations qualifying under either code are typically exempt from most federal, state, and local taxes.

States have recognized the unique status of nonprofit health care organizations and the benefits this status affords them. When nonprofit corporations convert, most states require them to turn their assets over to another nonprofit organization dedicated to similar purposes. Typically, state attorneys general enforce laws governing the transfer of assets from nonprofit to for-profit entities.

The monetary value of the HMO becomes critical when a nonprofit converts to a for-profit entity. Several questions need to be raised. How much is the entity worth? How much of that worth should be returned to the community? In what form should it be returned? Who should be involved in making those decisions?

Many large nonprofit conversions gained national attention when their assets were significantly undervalued. When Health Net, one of the largest HMOs in California, converted, it was initially undervalued. Various advocacy groups succeeded in blocking the deal and called for greater governance of the conversion process. When Blue Cross Blue Shield of California converted to for-profit status, the HMO initially put $200 million into a fund for charitable purposes. After negotiations were complete and a more accurate valuation done, Blue Cross was required to transfer $3.3 billion to health care charities.[7]

Both cases led California to clarify its standards for evaluating HMO conversions. The state enacted legislation that assessed a nonprofit entity converting to for-profit status by the value of its equity, adjusted for the market value of its assets. However, an HMO may have value beyond the equity shown on its balance sheet, say in existing contracts and clients, a network of providers, an experienced management team, a trademark, and "goodwill." Experts have suggested several approaches to assessing an HMO's value, including the discounted cash flow approach and the earnings-per-share approach.[9]

Once a converting HMO's value has been ascertained, the next step is to determine what part of the value should be returned to the community. Since the HMO was incorporated as a nonprofit entity, many people argue that its entire value should accrue to the community. The amount designated for the community can be distributed several ways. For example, the new for-profit corporation could distribute shares, and the community's trustees could decide on the amount of stock to be offered in public sale. Alternatively, the converting HMO could offer its negotiated share of the value of the converting entity. Most states require HMOs to contribute their net worth (the difference between their assets and liabilities) to a charitable trust upon conversion.

Minnesota does not have explicit laws governing health care conversions, but Rep. Lee Greenfield, DFL-Minneapolis, has introduced a law this legislative session outlining the state's role when hospitals convert. Al-

A Healthier Future

Southern Minnesota

Seeking quality primary care trained or emergency medicine physician(s) to practice in ***Blue Earth, Fairmont, Owatonna and Worthington.***

- Stellar Emergency Medicine Practice
- Full-time, regular part-time and moonlighting opportunities
- No restrictive covenants
- Fully accredited CME programs
- St. Paul malpractice insurance
- Competitive bonus, benefit and compensation packages.



ACUTE CARE, INC.

Respond to Melissa Milliken, CMSC, CMSR, Director of Development, 515-964-2772, 800-729-7813 or send CV to P.O. Box 515, Ankeny, Iowa 50021.

though all acute care hospitals in Minnesota are nonprofit organizations, no law requires them to be so. The proposed legislation would require the attorney general's office to review the process of conversions. Public hearings would be held, and the attorney general, together with the commissioner of health, would consult and verify that specific criteria are met in the conversion process.

Other states are looking closely at the nonprofit status of HMOs and the community benefits HMOs provide. Many are assessing the community or public benefit of providing nonprofit status and asking whether that benefit is enough to distinguish the nonprofit organization from a similarly situated for-profit. Massachusetts' attorney general recently developed voluntary guidelines for HMOs to develop and maintain community benefit programs. Examples of such programs include plans that target the working poor, victims of domestic violence, the elderly, minorities, and the disabled. Both for-profit and nonprofit HMOs are encouraged to submit annual reports detailing their community service.[10]

Conclusion

Nearly every legislative session some group or individual proposes allowing for-profit HMOs in Minnesota. While the debate is lively, the proposal has little chance of passage. Why? In part, the Legislature reflects local norms and community opinion, and we should not underestimate Minnesotans' aversion to for-profit health care. Last summer, strong public opposition prevented a bid from the for-profit, Texas-based Champion Healthcare Corporation to purchase the county-owned Itasca Medical Center. Yet the public has *not* resisted a pending offer from a coalition of local nonprofit health care companies—Allina Health System, Benedictine Health Systems, and the Duluth Clinic—to purchase the hospital.

Minnesota is forging a unique path in the HMO arena. Although some people may criticize the consolidation of the local market and the dominance of a few health plans, especially in the Twin Cities, our health care costs are among the nation's lowest and our quality among the highest. The cause and effect of these outcomes and the role nonprofit status plays will continue to be the topic of research and much debate. For now, we have the distinction of being the only land of nonprofit HMOs. MM

Lynn Blewett is the director of the Health Economics Program, Division of Health Policy and System Compliance, Minnesota Department of Health. Stella Hofrenning is an economist with the program. Parts of this paper were previously published in January 1996 by the Department of Health as a Health Economics Program Issue Paper, "Nonprofit and For-Profit HMOs."

REFERENCES

1. Roundtable: The for-profit, not-for-profit HMO debate; how can 49 states be wrong? Minnesota Physician January 1997;10: 18-25.
2. Ermann D. Health maintenance organizations: the future of the for-profit plan. Journal of Ambulatory Care Management 1986; 9(2):77-81.
3. Schlesinger M, Gray B, and Bradley E. Charity and community: the role of nonprofit ownership in a managed health care system. Journal of Health Politics, Policy and Law Winter 1996;21(4): 697-751.
4. InterStudy competitive edge, part II: industry report, September 1995:8.
5. Minn. Stat. §317A.011, subd. 6 (1996).
6. Minn. Stat. §62D.03 and ch. 317A (1996).
7. Hamburger E, Finberg J, and Alcantar L. The pot of gold: monitoring health care conversions can yield billions of dollars for health care. Clearinghouse Review August-September 1995; 29(5):475.
8. Middleton M. Nonprofit board of directors: beyond the governance function. In: Powell W, ed. The nonprofit sector: a research handbook. New Haven, Connecticut: Yale University Press, 1987, 714.
9. Finkler A. Merger and consolidation: what is the target organization worth? Healthcare Financial Management 1985;39(3):25.
10. Pact between Massachusetts HMOs and AGs office calls for plans to report annually on public service. State Health Watch March 1996:7.



SPECIALIZE IN AIR FORCE MEDICINE.

ER Physicians. Radiologists. OB/GYNs and other specialists! Today's Air Force gives you the freedom to specialize without the financial overhead of running a private practice. Talk to an Air Force medical program manager about the tremendous benefits of becoming an Air Force medical officer:

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay each year

Examine your future in the Air Force. Learn if you qualify. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

Family Practitioners



Mork Clinic – Anoka

The history...

Mork Clinic provides the people in Anoka and Elk River the best possible health care available. The founder of Mork Clinic, Dr. Frank Mork, established the clinic in 1931, and in 1988, to keep pace with the ever growing community, the clinic expanded to Elk River. The practice now includes 31 physicians with over 150 support staff in a variety of specialties, including Family Practice, OB/GYN, Internal Medicine, Pediatrics, General Surgery, ENT, Gastroenterology, Rheumatology, Allergy, Orthopedics, Nurse Practitioners and Physician Assistants.



Mork Clinic – Elk River

The opportunity...

As our suburban communities grow, we find the need for additional staff. We are seeking Family Practitioners at both the Anoka and Elk River sites to work **flexible full time.** Each physician sees approximately 30 patients on a daily basis, and is supported by a full staff of health care professionals.

The benefit...

Mork Clinic is an independently physician run clinic. Physicians are eligible to become shareholders after working with the clinic for two years. Each shareholder has a stake in how the clinic is run and the types of benefits offered. These positions offer a competitive compensation and benefits package.

The beginning...

Embark on a career journey that is fulfilling and rewarding and become a member of a team of physicians playing an integral part in the community's health and welfare. For further information, please contact Lori Fake at (612) 883-5337 or (800) 472-4695. For consideration, forward your CV to: HealthPartners, Physician Services, PO Box 1309, Minneapolis, MN 55440. You may also e-mail Lori at lori.m.fake@healthpartners.com.

MORK CLINIC P.A.

in affiliation with HealthPartners

EO/AA Employer

FAMILY PHYSICIANS

The University of Minnesota, Dept. of Family Practice offers teaching, administrative, and clinical practice opportunities in our state-of-the-art community residency program clinics affiliated with North Memorial Medical Center and St. Joseph's HealthEast. Full-range family practice. Attractive benefits package. ABFP, MN license, teaching experience. Call for full description and qualifications. (612) 624-2401 or view our Web page at:

http://www.med.umn.edu/fp/index.htm

The University of Minnesota is an Equal Opportunity Employer.

Affiliated COMMUNITY *Medical Centers, P.A.*

Join the security of a large multispecialty group located in Southwest and West Central Minnesota Communities of 3,700 to 19,000. All areas flourish with four-season recreational opportunities, strong economies and excellent education where family and lifestyle are a priority. Outstanding benefits for BE/BC physicians in:

Dermatology	Neurology
Family Practice	Ob-Gyn
General Surgery	Orthopedic Surgery
Internal Medicine	

Contact: Janiece Durham
Physician Recruitment Coordinator
Affiliated Community Medical Centers
101 Willmar Avenue SW
Willmar, Minnesota 56201-3591
320-231-6366

For-Profit and Not-for-Profit Health Care Organizations

An Annotated Bibliography

The articles summarized contrast the behavior and outcomes associated with for-profit and nonprofit health care.

Robert Koepp, M.A., and Steven H. Miles, M.D.

Of the many changes in the United States health care delivery system, none has garnered more concern than the rapid growth of for-profit hospitals, nursing homes, and managed care systems. Minnesota law disallows for-profit HMOs and specifically encourages not-for-profit health care entities. Nonetheless, for-profit health care institutions as ancillary services, holding companies, and hospitals are appearing on the Minnesota agenda. There is intense debate about whether our not-for-profit hospitals and clinics and managed care systems are acting too much like for-profit systems. There are also those who want to expand for-profit health care in Minnesota.

Money is at stake, but so are the social and moral values that we want our health care system to express. Among those values are consumer participation in the governance of health plans, community service, care for indigent and special needs populations, and the need for cultural diversity in our health care institutions. Even if a shift toward for-profit health care is a way to foster innovation and efficiency (neither claim is validated), will organizations established to generate profits for their owners provide health care to meet the needs and values of our society? These questions form the context for the articles summarized below.

This bibliography of for-profit and not-for-profit health care articles is sorted into five categories: health plans, hospitals, nursing homes, home care agencies, and articles providing historical or theoretical perspectives on these issues. We have selected articles that attempt to address the issues by generating or referencing data from empirical studies contrasting the behavior and outcomes associated with for-profit and nonprofit health care organizations. Resolution of the issues depends on this approach since many of the arguments voiced in this debate, both pro and con, rest on assumptions that can and should be subjected to empirical scrutiny.

Health Plans

Bryce HJ. Profitability of HMOs: Does non-profit status make a difference? Health Policy 1994;28:197-210.

Despite differences in tax status and laws governing financing and the distribution of gains from operations, both for-profit and nonprofit HMOs have economic reasons to be "profitable" in a common market that strongly affects costs and prices. The author examines market factors influencing the for-profit and not-for-profit HMOs and presents data comparing the profitability of 163 HMOs from around the country. Nonprofit and for-profit HMOs reported no significant difference between their average return on assets. The return on assets was not correlated with whether an HMO was for-profit or nonprofit.

Hasan MM. Let's end the nonprofit charade. New Engl J Med 1996;334(16):1055-7.

The author argues that investor-owned health plans are driving desirable cost-saving and quality-enhancing innovations in health care delivery systems and that nonprofit health plans are relics of the past, no longer viable in the current environment. Several controversial theses are put forth: market-based health care is necessary to guarantee quality and cost-effectiveness; investor-owned plans are responsive to the demands of patients and employers; nonprofit plans cannot compete in a rapidly changing environment; nonprofits are not better than investor-owned plans at protecting the welfare of patients; the appropriate role for nonprofits is to provide care for the indigent and to support medical education and research.

Nudelman PM, Andrews LM. The 'value added' of not-for-profit health plans. New Engl J Med 1996; 334(16):1057-9.

As a counterpoint to the previous article, the authors argue that for-profit and not-for-profit health plans fundamentally differ in purpose, values, attitudes, and behavior. They also claim that because for-profits are accountable to their investors, they can thrive by providing as little care as possible. They claim that not-for-profits have a stronger commitment to community service and do not treat the community simply as a market to be captured. The authors present some data to

suggest that not-for-profits give a greater percentage of premium dollars to consumers in the form of health care services, while for-profit HMOs strive to return 10 percent to 12 percent of premiums to shareholders and typically spend 10 percent to 20 percent on administrative costs. The authors argue that not-for-profit plans are more likely than for-profits to invest in preventive care and create partnerships with patients and providers that give them a meaningful voice in policy decisions.

Hospitals

Gray BH. Why nonprofits? Hospitals and the future of American health care. Front Health Serv Manage 1991; 8(4):3-32.

This article argues that the greatest challenges facing nonprofit hospitals are their own actions that undermine the legitimacy of their tax-exempt status. The author describes how the threat of takeover by investor-owned chains peaked in the early 1980s, then declined when rules governing capital depreciation changed and when prospective payment was introduced. Many people thought that nonprofits were inherently inefficient and could not survive in the face of competition. But nonprofits adopted many of the competitive strategies common among for-profits, and for-profit hospitals were not able to achieve an edge. As nonprofit hospitals behave more like for-profit competitors, the rationale for tax-exempt status is under increasing scrutiny. If tax-exempt status is a subsidy for providing services that would otherwise have to be provided by government programs, why shouldn't a for-profit hospital receive a similar subsidy? Why does tax relief adjust for not being allowed to raise capital in private markets by supposing that the financial backing for nonprofits is more altruistic than for for-profit hospitals? The author concludes that the future of private, nonprofit hospitals depends on their ability to be distinctively responsive to community needs in the face of strong environmental constraints.

Kane NM. The financial capacity of nonprofit hospitals. Health Aff 1993;12(3):234-7.

This paper offers an assessment of the financial capacity of 12 nonspecialty teaching hospitals in Boston. The author questions whether financial reporting requirements for hospitals are adequate to ensure public accountability. The teaching hospitals had accumulated assets in their affiliates worth $1 billion, representing 63 percent of the hospitals' long-term debt. Such discretionary cash helped to establish satellite facilities in higher-income communities and to duplicate state-of-the-art technologies rather than to make health care more affordable and accessible. The 12 hospitals also engaged in what the author calls a "capital arms race," responding to the systemic problem of excess capacity by upgrading and renovating facilities in order to compete more effectively for patients. Meanwhile, they eliminated "unprofitable" programs serving populations with special needs. The author proposes redefining tax-exempt status to require a minimum level of community services, imposing taxes on private nonprofit hospitals to support city hospitals and community health centers, and redistributing philanthropic resources to target providers serving economically disadvantaged communities.

Morrisey MA, Wedig GJ, Hassan M. Do nonprofit hospitals pay their way? Health Aff 1996;15(4):132-44.

This article examines whether the uncompensated care provided by nonprofit hospitals exceeds the community cost of tax subsidies to nonprofit hospitals. Data from 189 nonprofit voluntary community hospitals in California between 1988 and 1991 demonstrated that 80 percent of these hospitals met this standard in 1991, and that, on average, the cost of uncompensated care exceeded tax subsidies by almost two to one. The percentage of hospitals that failed to meet the standard declined from 39 percent in 1988 to 20 percent in 1991, indicating significant improvement. However, 40 percent of not-for-profit hospitals that failed to meet the uncompensated care standard in 1991 also had shortfalls in 1988. The authors suggest revising policies governing tax exemption to ensure that tax subsidies are balanced by community benefits.

Weissman J. Uncompensated hospital care: will it be there if we need it? JAMA 1996;276(10):823-8.

This article says there is a continuing need for uncompensated care as a safety net for the uninsured and underinsured, whose numbers are dramatically increasing despite efforts to expand Medicaid coverage. Uncompensated care accounts for an estimated 6 percent of total hospital costs, only a fraction of which can be offset by subsidies from state and local governments. The number of hospitals obligated under the Hill-Burton program to provide care regardless of patients' ability to pay declined from more than 4,000 in 1980 to fewer than 900 today, and will be less than 500 by the end of this decade. Current trends in ownership exacerbate the problem as not-for-profit and public hospitals, which between them account for more than 90 percent of uncompensated care, are being closed or acquired by for-profit groups.

Young GJ, Desai KR, Lukas CV. Does the sale of nonprofit hospitals threaten health care for the poor? Health Aff 1997;16(1):137-41.

This study of 17 private, short-term general nonprofit hospitals in California that were acquired by investor-owned corporations between 1980 and 1992 compares the pattern of uncompensated care for three years before and three years following acquisition. Changes in measures of uncompensated care for each acquired hospital were also compared with the changes that occurred in a comparison group consisting of all private, short-term general nonprofit hospitals doing business in California during the same period of time. As a proportion of hospitals' gross patient revenue, the amount of uncompensated care being provided was not significantly affected by acquisition. Rather, the data showed that acquired hospitals had provided less uncompensated care than the comparison group before acquisition, but that this difference disappeared after acquisition. The authors conclude that acquired hospitals are not likely to reduce the uncompensated care they provide, and fears

that they will reduce their commitment to community service may be unwarranted.

Nursing Homes

Fottler MD, Smith HL, James WL. Profits and patient care quality in nursing homes: are they compatible? Gerontologist 1981;21(5):532-8.

The authors studied the relationship between profitability and quality of care in 43 proprietary nursing homes in Southern California by assessing hours of nursing and nonnursing care per patient day and staffing ratios. The average profit margin of nursing homes was 5.83 percent, slightly higher than that for American industry in general. The study found that profitability and patient mix were most negatively related to quality. Quality was significantly higher in the less profitable facilities in the study, reflecting higher staffing ratios and thus higher labor costs. Quality was also higher in homes with smaller proportions of Medicaid patients, since rates charged to self-paying patients can be more easily adjusted to compensate for inflation. The authors suggest that public policies should be designed to reward nursing home administrators for achieving predefined outcomes rather than focusing on processes, methods, and penalties.

O'Brien J, Saxberg BO, Smith HL. For-profit or not-for-profit nursing homes: does it matter? Gerontologist 1983;23(4):341-8.

The authors review early research addressing the hypothesis that the profit vs. nonprofit orientation of nursing homes significantly affects patient outcomes. They suggest that the conflicting results of studies are due largely to: 1) inappropriate use of structural variables as proxies for patient outcome data to assess the quality of care being provided; 2) use of conflicting measures of the costs associated with the provision of care; and 3) failures to appreciate major interactions between the factors affecting costs and quality of care. The authors emphasize the need to employ multivariate analysis in the study of interactive effects of such factors as ownership, quality, and cost.

Aaronson WE, Zinn JS, Rosko MD. Do for-profit and not-for-profit nursing homes behave differently? Gerontologist 1994;34(6):775-86.

The authors merge data from three sources to construct a database containing information on utilization, prices, facilities, and resident characteristics for 449 nongovernmental nursing homes in Pennsylvania, of which 60 percent were for-profit and 40 percent were nonprofit institutions. Medicaid utilization did not differ according to ownership but was associated with independent living units, which not-for-profits use to subsidize Medicaid patients and for-profits use to increase their self-pay market share. For-profits didn't have lower Medicaid payment rates. Higher payment rates for nonprofits with high Medicaid use rates reflected higher levels of staffing. The study found evidence that not-for-profit status is associated with better care outcomes even though not-for-profits have a higher proportion of the oldest patients who are at greater risk for adverse outcomes.

Home Health Care

Estes CL, Swan JH. Privatization, system membership, and access to home health care for the elderly. Milbank Q 1994;72(2):277-98.

The authors surveyed 185 home health agencies (HHAs) from nine metropolitan areas in five states to determine the percentage of agencies that had refused clients for financial reasons. Data for 1984-86 and 1986-87 were compared to determine how access to home health care is affected by industry trends toward privatization and integration of HHAs into health care systems. The data for 1984-86 reveal that all not-for-profits and independent for-profit HHAs had similar rates of refusal for financial reasons (the rate was significantly higher for the for-profits that were also system members). The data for 1986-87 show little change for nonprofit system members and for-profit nonmembers, while both nonprofit nonmembers and, to a lesser degree, for-profit member agencies, had decreased their refusal rates. The evidence supports the hypothesis that when nonprofit HHAs are integrated into larger systems, they behave more like for-profits.

Ellenbecker CH. Profit and non-profit home health care agency outcomes: a study of one state's experience. Home Health Care Serv Q 1995;15(3):47-60.

This study compares the quality, efficiency, and cost of services provided by for-profit and nonprofit home health care agencies operating in Massachusetts in 1990. The authors found that while most services are similar, for-profits offer significantly fewer mental health, nutritional, and laboratory services and are less likely than their nonprofit counterparts to be involved with other community institutions in providing services. For-profit agencies delivered more visits per case than nonprofits, suggesting that the clients of nonprofit agencies might have unmet needs or that for-profit clients might be overutilizing services. In terms of efficiency, for-profits reported more administrative overhead hours than nonprofits. In all the service categories examined, rates charged by for-profit agencies were higher than nonprofit rates as well as industry averages. The authors conclude that the home health care industry has not benefited from the introduction of for-profit agencies.

History, Theory, and Ethics

Brock DW, Buchanan A. Ethical issues in for-profit health care. In: Gray BH, ed. For-profit enterprise in health care. Washington, D.C.: National Academy Press, 1986;224-49.

This excellent review discusses six common criticisms of for-profit health care, exposing both empirical and ethical assumptions around which debates have revolved. The authors show how arguments that for-profits fail to provide their fair share of charity care rest on a problematic assumption that for-profits have a special obligation to provide such care. The authors suggest that the problem of fair access to health care requires a societal response that goes well beyond the for-profit vs. non-

South Dakota
Room to Grow

Just imagine...the luxury of outdoor life in a traditional practice in Mitchell, South Dakota. The clinic is seeking a fifth BC/BE FP with OB. Quality family life, low crime rate...and No State Income Tax! Above national average compensation and comprehensive benefit package. Call today! Or send your CV to Pam Martin, Business Manager, Mitchell Clinic, 818 W. Havens, Mitchell, SD, 57301. 1-605-996-7772



STILLWATER
MEDICAL GROUP, P.A.

Be a part of a rapidly growing community in the historic city of Stillwater, MN.

An opportunity is available for a board certified physician in General Surgery in the scenic St. Croix River Valley.

- 42-physician, multi-specialty clinic, with two clinic locations in Stillwater, MN
- Comprehensive benefit package
- Excellent school system
- Ideal for families
- Located near the banks of the beautiful St. Croix River

If interested please call or send CV attention:
Liz Junker, H. R. & Benefit Specialist
921 S Greeley St.
Stillwater, MN 55082
(612) 439-1234 Ext. 327

profit debate. They reach similar conclusions after examining objections that for-profits represent unfair competition, or that they treat health care as a commodity rather than as a right. Concerns about adverse effects on medical education and research, as well as the potential for political abuse of economic power, may be well founded, but forces other than the profit motive probably exert more influence in producing such negative social results. The area of most serious ethical concern about the trend toward for-profit medicine is its potential to diminish the quality of the clinical relationship between physician and patient, and the core of that relationship—the quality of the care provided.

Ginzberg E. For-profit medicine: a reassessment. New Engl J Med 1988;319(12):757-61.
The author explores the rapid growth of for-profit health care organizations. Since 1965, when Medicaid and Medicare were introduced, a shortage of hospital beds in areas experiencing rapid population growth and a favorable reimbursement environment made the new for-profit hospital chains attractive to investment bankers. Analysts explain the growth of the for-profit chains in terms of five factors: 1) the chains were able to exploit economies of scale; 2) they were able to attract and retain strong management teams; 3) their strong planning and control systems enhanced decision making; 4) company-wide human resource policies placed tight controls on the use of nursing and support staff; and 5) they were able to respond more quickly than nonprofits to patients' demands for amenities. Despite these factors, for-profit chains were not able to gain a competitive cost advantage over nonprofits and had to rely on acquisitions to gain market share during the 1970s. With a shift toward ambulatory care and tighter reimbursement policies in the 1980s, expansion of the for-profit chains leveled off. As nonprofits adopted some of the organizational and management practices of the for-profit sector and gained access to the bond market, the apparent competitive advantages of the for-profit chains disappeared.

Salmon JW. A perspective on the corporate transformation of health care. Int J Health Serv 1995;25(1):11-42.
The author reviews the rapid shift to corporate health care delivery over the past three decades. While for-profit health care delivery was virtually unknown before 1970, by 1987 the four largest for-profit hospital chains each had revenues in excess of $3 billion. In 1990, 12 nursing home chains dominated the market, and 80 percent of nursing homes in this country are now proprietary. The growth of managed care, primarily in HMOs and PPOs, has followed a similar pattern. HMO enrollment rates have recently increased, with most of the growth occurring in the 48 corporate chains that now account for 84 percent of all HMO enrollees. Insurance companies own 47 percent of PPOs. Many not-for-profit providers have adopted the management practices of the for-profit sector, so that the differences between them, and traditional understandings of the purpose of health care, have become less clear.

Schlesinger M, Gray B, Bradley E. Charity and community: the role of nonprofit ownership in a managed health care system. J Health Polit Policy Law 1996; 21(4):697-751.
Debates about ownership and tax exemption of health care organizations have neglected organizations that do not engage directly in the delivery of health care, such as utilization review organizations (UROs). This article examines legal and conceptual rationales for linking community benefits and tax exemption in health care. It identifies five forms of community benefit distinct from the provision of charity care. The authors analyzed a national survey of UROs to determine whether ownership-related differences exist in the promotion of these community benefits. Nonprofit UROs were significantly more likely to engage in grant-funded research and to publicize information about the review process, thus promoting public goods associated with the creation and dissemination of information. Nonprofit UROs were also more community oriented, more strongly influenced by their boards of directors, and more likely to employ local treatment norms. The authors found that ownership-related differences relating to quality of care and cost shifting were minimal, with one exception: UROs established by physician groups showed greater concern for quality.

Findlay S. When not-for-profits decide to make a buck. Bus Health 1996;14(3):38-46.
This article reviews various trends contributing to the growing proportion of health care being delivered by for-profit organizations and contrasts the behavior of these organizations with that of not-for-profits operating in the health care field. A Harris survey found that 54 percent of the public thinks that the shift to for-profit health care is, overall, a bad thing, while only 19 percent say the shift is good. Still, no clear preference for one type of health care plan emerges; 26 percent would choose a nonprofit plan and 25 percent would choose a for-profit plan. In the public perception, the clearest differences between not-for-profit and for-profit plans center on their role in the community and on their ability to contain costs. Of those surveyed, 66 percent believe that nonprofit plans are more helpful to the community, and 63 percent believe that plans administered by nonprofits are more likely to cost less than their for-profit counterparts. MM

Robert Koepp is an administrative fellow at the University of Minnesota Center for Bioethics. Steven Miles is an associate professor of medicine in the department of geriatrics at St. Paul-Ramsey Medical Center and the University of Minnesota and associate faculty at the University of Minnesota Center for Bioethics.

This bibliography will be updated periodically. Updates will be available from the Center for Bioethics as a public service for the cost of copying and mailing.

Join a medical group rich in support in an area rich in natural beauty.

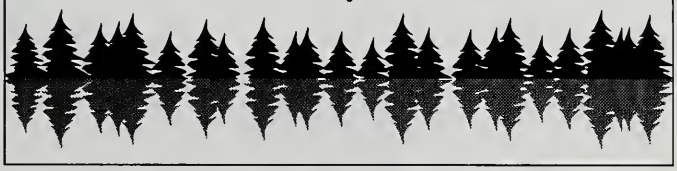
Duluth Clinic, a 300-physician multispecialty group, with 22 regional centers, and serving a regional referral population of 460,000, seeks to add physicians in the following areas:

EP Cardiology	Neurology
Dermatology	Neurosurgery
Emergency Medicine	Orthopedic Surgery
Family Practice	Pediatrics
Internal Medicine	Psychiatry
Nephrology	Radiology

We offer professional autonomy combined with excellent fringe benefits and generous vacation/CME time. If a quality lifestyle is important, this is your opportunity.

Please contact Mike Griffin or Marci Jackson, SMDC, 400 E. 3rd St., #40, Duluth, MN 55805 or call 1-800-342-1388 or fax 218-722-9952
or e-mail to: sr@smdc.org

SMDC
St. Mary's/Duluth Clinic Health System eoe



Staff Care, Inc.
"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS

- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging



Ask for:
John Moberly, ext. 2381 or
Melanie McReynolds, ext. 2387

(800) 685-2272
http://www.locumsnet.com

Staff Care is proud to sponsor *the Country Doctor of the Year Award*
Unable to place J-1 or H-1 physicians

The Right Prescription for Long Term Care Insurance

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED

The ABC's of Long Term Care Insurance: the physician as the ***Advisor*** to their patients, a potential ***Buyer*** of the product, and in many cases the designated ***Caretaker*** within their own family. The Minnesota Medical Association recognizes your request for education, information, and service on this topic and MMBR has developed a program to help you answer the questions being asked by your patients and your parents! It also lets members, spouses, parents, and parents-in-law purchase this type of coverage for up to ***20% off standard rates!***

For information on the MMA program, a schedule of educational workshops, or a private consultation for you or your family members, call MMBR at ***612-623-2860 or 800-298-6627.***

ROBERT K. SMITH, M.D.
2424 Main Street East
Anytown, MN 55505
(612) 555-1212

NAME _____

ADDRESS _____

℞

MMBR

INSURANCE SERVICES
MINNESOTA MEDICAL BUSINESS RESOURCES
OWNED BY MMA & HMS

TravelersInsurance
A Member of TravelersGroup

This plan is administered for the members of the Minnesota Medical Association by:

Newman Financial Services

NfS

MMA

MINNESOTA MEDICAL ASSOCIATION
MEDICINE'S VOICE IN MINNESOTA

The Monitor
News For Minnesota Physicians

Bill to Reduce 2 Percent Tax Meets Deadline

The MMA bill to reduce the 2 percent tax to 1 percent passed the House Health and Human Services Committee shortly after 9 p.m. on March 25 — just in time to meet the first committee deadline. To stay alive, bills must have passed out of the policy committees in either the House or Senate by March 26. The committee amended the bill, H.F. 316-Huntley, which originally called for reducing only the outpatient provider tax, so it now calls for reducing the hospital tax as well. After considerable discussion, the amended bill easily passed on a voice vote and was referred to the House Health and Human Services Finance Division.

Testifying in favor of the bill, MMA president-elect Kent Wilson, M.D., an otolaryngologist in St. Paul, stressed the MMA's commitment to the MinnesotaCare program, but said the 2 percent provider tax is not an appropriate funding source. "Minnesota does not ask teachers alone to pay for education, lawyers to pay for the criminal justice system, or realtors alone to provide housing for the homeless," Wilson said. "It is time to stop requiring health care providers to pay for health care for the uninsured." The MMA proposes reducing the tax as a first step toward replacing the provider tax with a broad-based funding source for the MinnesotaCare program. The current surplus in the Health Care Access Fund would make the transition relatively easy.

Each year, the state collects about $100 million more for the Health Care Access Fund than it spends on health care for the uninsured. The surplus in the fund, which was created for the specific purpose of funding the MinnesotaCare program, is expected to reach nearly $463 million by fiscal year 1999 and more than $687 million by the year 2001. The MMA bill's author, Rep. Thomas Huntley, DFL-Duluth, said, "I don't want a surplus in the Health Care Access Fund—particularly not of this magnitude—because someone might come along and want to use it to fund a stadium."

According to MMA projections, with the 1 percent reduction, the tax on health care revenues will still raise more money than is needed to cover expenditures for the MinnesotaCare program at least through the year 2001.

Several committee members were concerned that the MMA bill might be inconsistent with a bill the committee passed earlier the same evening, which would expand eligibility for the MinnesotaCare program to 175 percent of the federal poverty level for individuals ($13,545 annual income) and couples ($18,130 annual income).

The MMA supports the concept of increasing eligibility for the MinnesotaCare program, but is urging lawmakers to move toward a broad-based funding source first.

Announcements

Talking Points

"The MMA bill to reduce the provider tax has cleared its first hurdle, but a vigorous grassroots effort will be necessary to win passage," said David Renner, MMA director of legislation and public policy. "Lawmakers listen to their constituents." To obtain more information, call Wendy O'Donnell at 612/378-1875 or 800/DIAL-MMA (342-5662).

MMA Offers Payers' Perspective '97

The Minnesota Medical Association is offering Payers' Perspective '97 sessions in St. Paul on April 15, Bloomington on April 17, Duluth on April 22, St. Cloud on April 24 and May 1, and Mankato on April 29.

Representatives from Medica Health Plans, United HealthCare, Blue Cross and Blue Shield of Minnesota, the Minnesota Department of Human Services, Workers' Compensation/Department of Labor and Industry, HealthPartners, and The Araz Group will be actively participating in this session. The MMA has contracted with the Profile Group to facilitate these conferences.

The registration fee of $99 per session covers the cost of the workbook and lunch. For more information, call Vicki Westling at 612/378-1875 or 800/DIAL-MMA (342-5662).

Geographic Coalition Is on the Web

The Geographic Coalition's new Web site provides updates on Medicare payment reform and the coalition's strategy for correcting the problems in geographic payment inequity. Visit the Geographic Coalition at www.mnmed.org/gc



Viewpoint

Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

MMA Supports "Best Practice" Collaboration with APNs

Minnesota physicians consistently impress me with their willingness to take the initiative and resolve difficult issues. The work of the Ad Hoc Task Force on Advanced Practice Nursing is a prime example. Throughout the winter, the task force met to discuss ways for physicians and advanced practice nurses (APNs) to work together. We hope the resulting recommendations will help physicians forge new, collaborative relationships with APNs.

Clearly, the way we have done things in the past is changing. Everything seems to be in flux, including the traditional roles of physicians and nurses. As physicians become the leaders of medical care systems, they grow increasingly aware of the value of nursing to their patients. Trends in health care show a move away from independent practice and toward group practice. In this changing environment, the task force envisions APNs and physicians working more closely together within clearly defined collaborative practice arrangements.

Physicians and nurses have a long history of working together to provide services for their patients. The question is: What should the physician do and what should the advanced practice nurse do? The answer is — It depends.

The task force found there can be considerable variability in APN educational programs, certification processes, clinical training, and experience. They realized a one-size-fits-all approach wouldn't work. Therefore, the task force recommended an individual approach to determining an APN's autonomy within a collaborative practice framework and in conformance with state law. Both APN and physician would agree upon a written collaborative practice agreement that defines roles and responsibilities and includes the nurse practitioner prescribing agreement.

The task force stopped short of recommending legislation to require a written practice agreement, however, because it might result in overregulation and create barriers to efficient practice.

The task force's specific recommendations, adopted by the MMA Board of Trustees in February, are listed below.

1. APNs should work within a collaborative practice framework with physicians.

2. An APN's autonomy should be determined by mutual agreement between the collaborating physician and the APN. The APN's scope of practice is determined by state law and by the professional standards established by nursing organizations for education, training, and certification.

3. Within a collaborative framework, APNs should practice within the nursing specialty in which they have achieved their advanced education, training, experience, and certification.

4. Every collaborative practice arrangement should include support systems to allow the physician and APN to perform optimally in providing effective and efficient patient care. Support systems might include peer review, a continuous quality improvement process, and opportunities for continuing education.

5. Physician and APN prescribing rules and regulations should not create barriers to practice within collaborative practice arrangements, but should support the efficient and effective provision of patient care.

6. The MMA should support the nursing profession's efforts to standardize APN education, training, and certification processes.

7. The patient care services that APNs and physicians provide within a collaborative practice framework should be appropriately reimbursed.

8. The MMA should support the use of a written collaborative practice agreement and the continued use of the Nurse Practitioner Prescribing Memorandum of Understanding.

9. The MMA will support the nursing profession's efforts to regulate the appropriate use of APN titles. Appropriate APN titles are those officially recognized by the nursing profession and based on a nurses' advanced education, training, skills and certifications, and include the following APN categories: certified registered nurse anesthetist, certified nurse midwife, nurse practitioner (certified), and clinical nurse specialist (certified). Nurses strongly prefer these titles to terms such as "mid-level provider," "physician-extender," and "physician substitute."

10. The MMA will support, seek, and encourage ongoing dialogue with Minnesota nursing organizations.

These recommendations will guide us as we continue to discuss issues of mutual concern with nurses.

I would like to personally extend my thanks to Robert Meiches, M.D., the chair, and to the task force members for volunteering their time to help move the health care system forward.

Task Force Issues Report on Advanced Practice Nursing

The MMA Ad Hoc Task Force on Advanced Practice Nursing, chaired by Robert Meiches, M.D., recently issued a report calling for collaboration between physicians and advanced practice nurses (APNs) in providing patient care and in determining each APN's autonomy. The task force also recommended that the MMA support the nursing profession's efforts to regulate the use of APN titles and to standardize APN education, training and certification processes. The APN report includes extensive information about APNs and specific recommendations to guide MMA policy, which are summarized in "Viewpoint" by Timothy Crimmins, M.D., on the facing page. The MMA Board of Trustees has adopted the task force's recommendations.

Impetus for the Report

During the 1996 legislative session, the Minnesota Nurses Association (MNA) sought legislation to clarify the scope of practice of advanced practice nurses (APNs) and to expand their independent prescribing authority. Although the MMA agreed with the nurses about the value of more clearly defining APNs' practice autonomy, the MMA opposed several provisions in the bill including a proposal to give the nurses independent prescribing authority. The MMA asked legislators for a delay and assured them the MMA would meet with Minnesota nursing organizations to discuss the role of APNs and try to reach agreement on as many issues as possible.

The MMA formed the Ad Hoc Task Force on Advanced Practice Nursing to gather background information on APNs and to recommend a future direction for MMA policy. The task force included physicians who work with advanced practice nurses as well as four APNs, recommended by the Minnesota Nurses Association and the Minnesota Board of Nursing, who provided valuable input and participated in discussions, but did not vote on the final recommendations.

Findings of the Task Force

Task force members found there could be considerable diversity in APN educational programs, certification processes, clinical training, and experience, especially for nurse practitioners and clinical nurse specialists, which led them to conclude that each APN's autonomy within a collaborative practice framework should be determined by mutual agreement between the collaborating physician and APN in conformance with state law.

What Are APNs?

Advanced practice nurses are licensed registered nurses who have gained additional knowledge and skills through an organized program of study and clinical experience, and who are certified as APNs by a recognized, national professional nursing organization. Included in this category are certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, and clinical nurse specialists.

Currently, Minnesota law defines the scope of practice of registered nurses, but not a separate scope of practice for APNs. Like all registered nurses, APNs may perform "independent nursing functions" as well as any medical function delegated by a licensed physician except prescribing. Recent changes in Minnesota law gave certified nurse midwives the authority to prescribe and administer drugs and therapeutic devices within their practice as nurse midwives. Nurse practitioners and clinical specialists in mental health nursing may also prescribe, but the law requires there be a written agreement between the APN and the physician, which delegates the prescribing authority. The agreement is based on standards developed by the Minnesota Medical Association, the Minnesota Nurses Association, and the Minnesota Psychiatric Society.

The task force discussed nurses' concerns that a lack of a clear definition in Minnesota statute or rule of advanced practice nurses' scope of practice may cause confusion for the public and for those who work with or use the services of APNs. Minnesota law does not prohibit the use of the titles "nurse practitioner" or "clinical nurse specialist" but rather defines these titles for purposes of certain activities such as delegated prescribing and billing third-party payers for certain services. Representatives of the nursing profession want to ensure that nurses who use the title of nurse practitioner or clinical nurse specialist have attained the appropriate training, education, and experience.

At the recommendation of the task force, the MMA will support the nursing profession's efforts to regulate the appropriate use of APN titles and to standardize education, training, and certification processes.

Legislative Outlook

If Minnesota APNs decide to seek legislation to define their scope of practice, the proposal would probably address the following issues: independent prescribing, independent scope of practice, predetermined educational and certification requirements, title protection, and reimbursement.

The Minnesota Nurses Association introduced a bill this session that is similar to last year's legislation. The bill is not expected to move in 1997, but rather to serve as a "place holder" for legislation, yet to be drafted, that nurses would push for during the 1998 session, the second half of the biennium.

The recommendations of the task force will be useful as the MMA continues to engage in discussions with nursing representatives about the role of APNs and how to define it in statute.

LEGISLATIVE NEWS

Repeal of $400 Surcharge Is Introduced

The Minnesota Medical Association drafted a bill to repeal the $400 surcharge on physician license fees, H.F.1434/S.F.1237, which was introduced by Sen. Sheila Kiscaden, R-Rochester, and Rep. Mike Delmont, DFL-Lexington. The MMA is telling lawmakers that the surcharge was adopted at a time when the state had a budget shortfall. Now that the state's coffers are overflowing, it's time to repeal the surcharge.

Repeal of the surcharge is also included in a rural health bill, H.F. 511-Otremba/S.F. 438-Sams, which was drafted by the Minnesota Hospital and Healthcare Partnership (MHHP). Repeal of the surcharge is important to MHHP because the surcharge is making it hard for many border hospitals to recruit physicians. The House Health and Human Services Committee and the Senate Health and Family Security Committee passed the rural health bills and sent them to the House and Senate budget divisions.

In addition to repealing the surcharge, the MHHP bill would designate a sole community hospital as an essential community provider; ensure rural representation on the Minnesota Health Care Commission; establish a demonstration project for rural hospital consolidation and cooperation; and establish a grant and loan program to rural hospitals for capital improvements.

• • • • • • •

Repeal of Growth Limits Advances

A bill to repeal growth limits for health care providers and to replace the growth limits for health plans with "cost containment goals," S.F. 920-Morse, has passed the Senate Commerce Committee. The MMA is urging lawmakers to pass this bill. Repeal of the growth limits is one of the MMA's top priorities this session. The companion bill, H.F. 858-Huntley, which sets cost containment goals for both providers and plans, passed the House Health and Human Service Committee.

• • • • • • •

Bill Would Expand MinnesotaCare Eligibility

MinnesotaCare legislation, H.F. 1441 /S.F. 1208, has been drafted by the Legislative Commission on Health Care Access. The MinnesotaCare bill would:

- expand MinnesotaCare eligibility to 175 percent of the federal poverty level on July 1, 1997;
- disband the Minnesota Health Care Commission, an advisory committee representing physicians, hospitals, health plans, nurses, business, and consumers;
- retain the commission's Health Technology Advisory Commission, which issues reports on the costs and benefits of medical procedures;
- restate existing authority to enforce the pass-through of the 2 percent tax by allowing providers to file complaints; and
- freeze the loss ratios for health plans instead of gradually increasing them in accordance with current law.

• • • • • • •

MMA Improves BMP Bill

The Minnesota Medical Association has successfully proposed an amendment that greatly improves a Minnesota Board of Medical Practice bill. As originally drafted, the BMP legislation would have subjected physicians who failed to notify the BMP of a change of address within 30 days to the possibility of automatic suspension of their medical licenses. The MMA met frequently with the BMP to discuss concerns about this proposal. As introduced, the BMP bill, S.F. 38-Sams/H.F. 75-Koskinen, more closely echoed the board's intent to apply the provision when physicians who are "under investigation" fail to notify the BMP of an address change. The MMA amendment narrowed the focus still further so that the bill now applies only to physicians who have been served notice of conference by the BMP, or are under a BMP disciplinary order or corrective action agreement. Physicians may petition to have their medical licenses reinstated.

• • • • • • •

Safety Belt Bill Advances

The Senate Transportation Committee passed an MMA-supported bill, S.F. 170-Dille, to make failure to wear a seat belt a primary offense. Currently, officers may only issue a citation if they have stopped the driver for another violation. The companion bill, H.F. 1066-Greenfield, is waiting to be heard in the House Transportation and Transit Committee.

• • • • • • •

Birth Defects Registry

The bill, S.F. 430-Berglin/H.F. 844-Rest, to establish a statewide birth defects registry in Minnesota pits research supporters against people who fear loss of privacy rights. The March of Dimes is pressing for this legislation. Hospitals are concerned that collecting information from medical records about birth defects may violate data privacy protections under the Americans with Disabilities Act. S.F. 430 passed the Senate Health and Family Security Committee and the Senate Judiciary Committee, and H.F. 844 passed the House Health and Human Services Committee and is awaiting a hearing in the House Data Privacy Subcommittee.

LEGISLATIVE NEWS

MMA Supports Later School Start Time Bill

The MMA participated in a news conference in March to announce the introduction of a bill to require Minnesota public schools to start after 8 a.m. The bill, S.F. 1300/H.F. 1259, was drafted by the Children's Defense Fund and introduced by Rep. Matt Entenza, DFL-St. Paul, and Sen. Sandra Pappas, DFL-St. Paul.

"Teenagers' biological needs are not being met," Pappas told the news conference. "High school students are falling asleep in their first hour classes. This is not optimal for learning and it's not good for kids' health."

Many Minnesota junior high schools and high schools start shortly after 7 a.m. and dismiss students as early as 1:45 p.m. while some elementary schools begin as late as 9:40 a.m.

"Current school policy is designed around bus schedules, not the needs of adolescents and the community," said Entenza. "The majority of juvenile crimes occur in the afternoon when teenagers are out of school incredibly early and are unsupervised."

Concern about school start times has been increasing for three years—ever since the MMA wrote to all state school superintendents, urging them to eliminate early start times for teenagers. Responding to a resolution adopted by the 1993 MMA House of Delegates, the MMA told superintendents in the spring of 1994 that the timing of the adolescent sleep period is biologically geared to later hours. Teenagers have difficulty falling asleep as early as younger children do, and they tend to sleep later in the morning. Adolescents need more than nine and a half hours of sleep—more sleep than younger children or adults.

Although the MMA letter and news release stirred a good deal of discussion, only one Twin Cities school, Edina High School, has actually switched to a later start time.

The Minnesota School Board Association opposes the bill because it does not want a new mandate from the state. As *The Monitor* goes to press, the bill is waiting to be heard in the House Education Subcommittee.

Tobacco Licensing Bill Moves Forward

In a victory for the MMA and other members of the Smoke-Free 2000 Coalition, a bill to license stores that sell tobacco, S.F. 6-Junge, emerged from the Senate Commerce Committee stronger than its companion bill, H.F. 117-Rest, which passed the House unanimously in February. In an effort to target teenage smokers, the Commerce Committee approved an amendment offered by Sen. Cal Larson, R-Fergus Falls, that states that anyone under age 18 who uses a driver's license or ID card to illegally buy cigarettes could have his or her license suspended. The Senate Commerce Committee passed the bill, drafted by the Smoke-Free 2000 Coalition, after adopting the following amendments:

- Reduce the number of mandatory "stings" to one a year. The compliance check requirement was deleted from the House bill.
- Ban self-service sales of individual packs of cigarettes, but allow the self-service sale of cartons that are in sight of a clerk. The House bill allows the self-service sale of all tobacco products within the clerk's line of sight.
- Delete the ban on slotting fees—the practice of paying a retailer to place tobacco products in a particular place, but require manufacturers to report how much they pay for tobacco promotion to the Department of Commerce. The ban on slotting fees was also deleted from the House bill.

Both the House and Senate bills would:

- require retail outlets that sell tobacco to be licensed,
- set fines for the person who sells tobacco to anyone under age 18 and for the license holder,
- allow local communities to keep their present power to pass more restrictive penalties.

The Senate bill is awaiting floor action. Differences between the Senate bill and its weaker House companion bill will be worked out in conference committee.

Federal Drug Administration rules took effect in February that require clerks to ask people who look younger than 27 years old to present photo identification for proof of age before selling them cigarettes. Penalties include $250 fines.

MMA Supports Police on Concealed Weapon Permits

As a member of the Gun Violence Action Team, the Minnesota Medical Association issued a statement to the media supporting the right of local law enforcement officials to keep their authority to decide whether to issue someone a permit to carry a concealed weapon. Sen. Pat Pariseau, R-Farmington, and Rep. Hilda Betterman, R-Brandon, have introduced a bill, H.F. 985/S.F. 792, known as the Right to Carry Bill, which would require police chiefs to issue a permit to carry a concealed weapon to any citizen who can demonstrate proficiency and has no criminal record. The Women's Firearms Alliance of Minnesota supports this bill, arguing that criminals would hesitate to attack women if they believe they might be armed. The

LEGISLATIVE NEWS

MMA and other members of the Gun Violence Action Team oppose the bill because its passage would mean that local law enforcement officers would no longer have the discretion to decide who can carry a concealed weapon.

• • • • • • •

MMA Amendments Defuse Naturopaths' Bill

Naturopaths have agreed to remove the provisions in their bill that sparked opposition from the Minnesota Medical Association. The main goal of the naturopaths' bill, S.F. 523-Berglin/H.F. 396-Wejcman, is to allow naturopaths who have graduated from an approved naturopathic medical college and passed licensing examinations to be licensed under the Minnesota Board of Medical Practice. As originally drafted, the naturopaths' bill would have allowed them to perform a number of procedures that constitute the practice of medicine. The MMA strongly opposed those provisions.

After lengthy discussions between the MMA and representatives of the naturopathic community, however, the chief author of the naturopaths' bill, Sen. Linda Berglin, DFL-Minneapolis, agreed to introduce the following MMA amendments:

- Delete the provision to allow naturopaths to refer to themselves as "naturopathic physicians."
- Delete the provision to allow naturopaths to perform minor surgery.
- Specify that naturopaths who attend home births must have a written agreement with a physician on file at the BMP.
- Delete a provision to allow naturopaths to prescribe certain legend drugs.
- Create a task force to study the issue of naturopathic prescribing so that this issue may be revisited next session.

The Senate Government Operations Committee accepted the MMA amendments March 5 and referred the bill to the Senate Health and Family Security Committee. The MMA is not opposing the naturopaths' licensing bill, as it is amended.

• • • • • • •

Patient Protection Bills Proceed

Three separate bills calling for patient protections are moving through committees at the Minnesota Legislature. All three bills would:

1) ban "gag clauses" or contracts that restrict communication between health care providers and their patients,

2) require disclosure of provider financial incentives, and

3) provide additional consumer assistance.

Many of the provisions in these bills are similar to ones that have long been supported by the Minnesota Medical Association and the American Medical Association.

Although all three bills include the consumer protections listed above, they differ in some respects.

The attorney general's office and a coalition of consumers, nurses, and advocates for the disabled and the mentally ill, have drafted consumer protection bills that would include provisions to require continuity of care in addition to the provisions listed above. The bills, S.F. 960-Berglin /1365-Wejcman, and H.F. 929-Orfield/S.F. 829-Morse, would require health plan companies to provide continuity of care and access to specialty care for certain enrollees and would prohibit certain exclusive arrangements.

The Minnesota Council of Health Plans, formerly the HMO Council, has designed its consumer protection bill, HF 354-Huntley/S.F. 320-Wiener, to indirectly affect self-insured plans by regulating the providers who contract with them. "Battle lines have been drawn over whether the protection provisions should apply to self-insured companies with the Minnesota Council of Health Plans on one side and the Business Health Care Action Group on the other," said David Renner, MMA director of legislation and public policy. BHCAG, a coalition of 23 large self-insured employers, does not oppose the consumer protections per se, but it does object to any state regulations that would affect self-insured employers. BHCAG employers are exempt from many state regulations under the Employee Retirement Income Security Act.

Additional provisions in the HMO bill would:

- prohibit outpatient mastectomies;
- give health plans a tax credit to offset the cost of the current assessment for the Minnesota Comprehensive Health Association, the state's high risk insurance pool for people who have been denied private health insurance for medical reasons;
- expand MinnesotaCare eligibility up to 175 percent of the federal poverty level, an income of $13,545 for an individual or $18,130 for a couple; and
- establish a procedure to review proposed state health care mandates.

• • • • • • •

Direct Access to ACOG's Bill Moves Forward

The Minnesota House of Representatives unanimously passed a bill proposed by the Minnesota Section of the American College of Obstetricians and Gynecologists (ACOG), H.F. 447-Murphy, to require Minnesota health plans to allow women direct access to obstetricians

LEGISLATIVE NEWS

and gynecologists for annual preventive health examinations, maternity care, and treatment for acute gynecologic conditions or emergencies. Women would not have to obtain a referral or prior approval, and health plans would not be allowed to charge higher copayments, coinsurance, or deductibles. The bill would not require plans to cover any new medical service and it would only allow women direct access to ob/gyns in their existing health plan network.

The Senate Commerce Committee unanimously passed the Senate companion bill, S.F. 389-Wiener, and referred it to the Senate floor. It was sent back to the Health and the Family Security Committee, which clarified, for the record, that nothing in the bill would penalize providers who have acted as "gatekeepers" in the past. Health plans have stated that they intend to amend contracts that are affected by this bill. The bill passed Health and Family Security and now awaits Senate floor action.

The ACOG bill is consistent with MMA policy. The 1995 MMA House of Delegates passed a resolution supporting the preservation of women's ability to directly access preventive health, diagnostic, and treatment services provided by ob/gyns.

MMA Supports Ban on Tobacco Billboard Ads

The MMA wrote a letter of support to Rep. Michael Paymar, DFL-St. Paul, for his bill to ban advertising tobacco products on outdoor billboards and buses, H.F. 688. In the MMA letter, which was distributed to members of the House Commerce, Tourism and Consumer Affairs Committee, Ray Christensen, M.D., MMA president, wrote: "The MMA is concerned that billboard and bus advertisements will make smoking appear glamorous and fun especially to young people. In fact, nicotine is highly addictive and is linked to premature death from lung disease, cancer, and heart disease." The bill passed by a narrow 12-11 roll call vote with two members absent, and was sent to the House floor. The bill is awaiting a hearing in the Senate.

Immunization Registry Bills Proceed

The House Health and Human Services Committee passed the immunization registry bill, H.F. 259-Slawik/S.F. 126-Berglin, and referred it to the House Judiciary Committee. This proposal would create guidelines for the coordination of state and local immunization registries. The Senate companion bill, S.F. 126-Berglin, passed out of the Health and Family Security Committee and the Judiciary Committee.

LEGAL NEWS

Court Decision Clarifies Workers' Comp Payment

The Minnesota Supreme Court reversed a decision of the Workers' Compensation Court of Appeals and granted the claim of injured employee LeRoy Spaeth for workers' compensation payment of medical charges to treat his work-related injury. The MMA had filed an *amicus curiae* brief supporting Spaeth's claim and urging the Supreme Court to reverse a decision that injected considerable confusion into the issue of reimbursement for services that are later found to be compensable.

The Supreme Court decision reverses the Workers' Compensation Court's finding that Cold Spring Granite Company, a self-insured employer, was not obliged to pay the employee's health care provider the difference between the amount due under the workers' compensation medical fee schedule and the discounted amount the health care provider accepted, pending resolution of the dispute over primary liability for the claim. The Supreme Court decision clarifies that self-insured employers are liable for medical charges allowed under the workers' compensation medical fee schedule in effect at the time services are provided.

Lawsuit Targets Firearms Industry

A lawsuit has been filed in New York that seeks to hold the firearms industry responsible for the thousands of people who are wounded and killed each year with illegally obtained handguns. The lawsuit targets top firearms manufacturers including Colt, Remington, and Smith & Wesson.

The lawsuit charges that through overproduction of handguns, lax supervision of firearm dealers, and an effort to resist tighter distribution practices, the industry has "created a pool of negligently distributed products that get into the hands of kids and criminals." Case law is on side of the firearms industry. In the past, gun manufacturers have successfully argued they should not be held responsible for misuse of a lawful, regulated product.

ANNOUNCEMENTS

MMA Will Present Medicare Billing Conference

The Minnesota Medical Association will present a conference on compliance with Medicare billing rules in various locations throughout the state during May. The seminar is geared for hospital CEOs, CFOs, compliance officers, office managers, health information management staff, physicians, consultants, attorneys, and anyone else who might be responsible for ensuring compliance by clinics and hospitals. The MMA has arranged for David Glaser of the Minneapolis law firm of Frederikson & Byron, P.A., to provide information about compliance programs and to answer questions. Currently, seminars are scheduled for May 1 in St. Paul, May 7 in St. Cloud, May 8 in Marshall, May 14 in Duluth, and May 21 in Fargo. The registration fee of $69 includes a continental breakfast. Watch your mail for more information, or call Vicki Westling at 612/378-1875 or 800/DIAL MMA (342-5662).

Date Is Set for Public Health Forum

You are invited to attend an all-day conference on collaborative efforts between medicine and public health in Minnesota, presented by the Minnesota Medical Association, the Public Health Association, and the Center for Population Health. The conference will be held on Friday, June 13, at the Earle Brown Heritage Center in Minneapolis. The keynote speaker is Philip Lee, M.D., the recently retired assistant secretary for the U.S. Department of Health and Human Services. The conference, which is funded by a Robert Woods Johnson Foundation grant, will build on the American Medical Association/American Public Health Association "Medicine/Public Health Initiative." Watch your mail for more information.

MMA Sponsors Dunlap Race

The Minnesota Medical Association is sponsoring the Anne Barber Dunlap Race to be run May 31 at Lake Harriet. The race is held in memory of Dunlap, a former member of the Northwest Club Run, who was murdered last year. Representatives of the race, who were Dunlap's friends and running companions, donated the 1996 race proceedings to the MMA "Stop the Violence" Campaign.

St. Thomas Names Building for MMA Member's Family

A science building under construction at the University of St. Thomas will be named Owens Science Hall to honor the family of Ben Owens, M.D., of Hibbing. Owens is memorializing his late brother, Frank Owens, M.D., and his parents Mary and Ben Owens, Sr. Owens Science Hall will house the undergraduate biology, chemistry, and physics departments.

Wellstone Introduces Patient Protection Act

The American Medical Association supports Sen. Paul Wellstone's Patient Protection Act, which would establish a federally funded consumer assistance office in each state to give information about health plans and insurers, require disclosure by health plans including self-insurers, set standards requiring health plans to show their policies for care decisions, and require health plans to provide an appeals procedure.

AMA Aims to Improve Care of Dying

The American Medical Association, along with the American Hospital Association and the American Association of Retired Persons, has launched an effort called Last Acts aimed at improving care of the dying. The goal is to make pain control and home care for the dying more readily available through such means as increased insurance coverage for hospice care. The AMA believes that more compassionate and better care of the dying would reduce the demand for physician-assisted suicide. The Robert Woods Johnson Foundation has given $1.7 million to Last Acts.

Grams Introduces EMS Bill

Minnesota Sen. Rod Grams has introduced the Emergency Medical Services Act of 1997, S. 238, which would require Medicare reimbursement for emergency ambulance services to be based on what a prudent person would define as an emergency rather than on the diagnosis made in the emergency department. The bill would also create two councils to advise Congress on how to improve the EMS system.

The Monitor
APRIL 1997

President
Raymond G. Christensen, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Director, Communications
Mark S. Vukelich

Editor
Lorrie Holmgren

Yes I would like MMBR to bridge the gap by providing:

- ❑ A personalized financial review
- ❑ Retirement planning review
- ❑ College funding analysis
- ❑ Life insurance rate information
- ❑ Information regarding mutual funds*
- ❑ Information on annuities
- ❑ Upcoming financial seminars

Name _____

Address _____

City_____ State_____ Zip_____

I prefer to be contacted at my ❑ Home ❑ Office

Phone number _____

MINNESOTA MEDICAL BUSINESS RESOURCES

3433 Broadway Street NE, Suite 375, Minneapolis, MN 55413 • 612-623-2860 • 800-298-6627

*Secutities offered through Washington Square Securities, Inc. 20 Washington Ave. S., Minneapolis, MN 55401 (612) 372-5507

MNMED

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

FIRST CLASS PERMIT NO. 24852 MINNEAPOLIS, MN

POSTAGE WILL BE PAID BY ADDRESSEE

MINNESOTA MEDICAL BUSINESS RESOURCES
3433 Broadway Street NE, Suite 375
Minneapolis, MN 55413-1761



Keep Your Balance.

With the new EquiLink℠ annuity from Great American® Life Insurance Company, your retirement dollars are safeguarded with the traditional features of a tax-deferred[1] fixed annuity while also participating, in part, in any increases of the S&P 500® Index, a widely accepted and broad measure of the performance of the major U.S. stock markets.

So you get both the inflation-beating GROWTH potential normally associated with a stock market index ***and*** the SECURITY of a tax-deferred annuity — an annuity with a money-back guarantee at the end of each term and additional interest on a portion of your principal!

EQUILINK℠

An Annuity with Interest Earnings Linked to the S&P 500® Index!

PHYSICIAN APPROVED MMBR ASSOCIATION ENDORSED

For more information call: **1-800-298-6627**
MMBR Insurance Agency
3433 Broadway St. N.E.
Suite 375
Minneapolis, MN 55413

Underwritten by:

GREAT AMERICAN®
LIFE INSURANCE COMPANY
250 East Fifth St.
Cincinnati, OH 45202

[1] Tax laws are subject to varying interpretations and possible changes. Distributions are subject to taxation at time of receipt. Distributions prior to age 59 1/2 are subject to possible tax penalties and, for a TSA policy, significant tax law restrictions. Please consult your agent and tax advisor for further information.

"Standard & Poor's®" and "S&P 500®"are trademarks of The McGraw-Hill Companies, Inc. and have been licensed for use by Great American® Life Insurance Company. EquiLink℠ is not sponsored, endorsed, sold, or promoted by Standard & Poor's, and Standard & Poor's makes no representation regarding the advisability of purchasing this product.

EquiLink℠ is a fixed annuity with interest earnings linked, in part, to the S&P 500® Index.
It is not a variable annuity, mutual fund or equity investment.

4173 (1/97)

Rural Enrollment in MinnesotaCare

Barbara P. Yawn, M.D., M.Sc., and Sarah Krein, R.N., B.S.N.

ABSTRACT

Many rural Americans remain underserved and uninsured. Attempts to initiate national health care reform and universal health insurance coverage have stalled. The impetus to continue reform and universal coverage efforts has shifted back to the state level. Minnesota's health reform efforts resulted in the 1992 MinnesotaCare legislation, which included a subsidized insurance program.

As of October 21, 1995, a total of 91,140 people were enrolled in MinnesotaCare. Enrollees are found in every county in the state and represent approximately 2.1% of Minnesota's total population and 2.4% of the state's population under age 65. Estimates of Minnesotans who are uninsured and therefore potentially eligible for this subsidized insurance plan range from 6% to 13%.

MinnesotaCare enrollment estimates vary from a high of 10.8% of Red Lake County's population who are under age 65 and report incomes over 100% of the poverty level to a low of 1.5% for similar residents of Nicollet County. Counties with the lowest percentage of MinnesotaCare enrollees are clustered in southern Minnesota, especially the southeastern counties. Those with the highest percentage of enrollees appear to cluster in central Minnesota. MinnesotaCare enrollment is negatively associated with the size of the county's minority population and population density.

An estimated 15.8% of all Americans and 17.0% of rural Americans are uninsured.[1,2] Attempts to provide health insurance coverage for the uninsured through national health care reform have stalled, and the impetus has returned for state-initiated health care reform. The high proportion of rural residents among the uninsured and special rural concerns, such as geographic dispersion and population sparsity, cultural climate, and access to health care services, present important considerations for states that are implementing new programs for the uninsured.

In 1992, the Minnesota Legislature passed the first version of MinnesotaCare (formerly known as HealthRight).[3] Included in this health reform package was a subsidized insurance program for uninsured persons under age 65 with yearly income levels above those necessary for Medicaid eligibility but less than 275% of the poverty level. Before applying for MinnesotaCare, a person or family has to be without insurance coverage for a minimum of four months and not have had access to employer-based insurance within the past 18 months. Eligibility requirements have been modified several times. Table 1 outlines current requirements. Participants contribute to premiums in accordance with their yearly family income (Laws of Minnesota 1992, Chapter 549). For example, in 1993, a family of four would have contributed $25 to $221 per month, depending on the family's income.

As of October 21, 1995, a total of 91,140 Minnesotans were enrolled in MinnesotaCare (written communication, Jeanyne B. Slettom, Public Information Officer, MinnesotaCare, December 1, 1995). Enrollees include residents from every county in the state and represent 2.1% of Minnesota's total population and 2.4% of the state's population under age 65. Before MinnesotaCare was passed, estimates of the percentage of uninsured Minnesotans ranged from 6% (262,506 people), based on a Health Access Commission Survey, to 13% (568,762 people), based on the Current Population Survey, U.S. Bureau of Census.

Unfortunately, none of the available estimates reflects actual MinnesotaCare eligibility. We do not know the actual number of uninsured persons in Minnesota, and we also do not know the number of uninsured who are *not* eligible for MinnesotaCare. For example, uninsured families with incomes greater than 275% of the poverty level, single individuals with incomes greater than 125% of the poverty level, and persons with access to insurance (employer-subsidized, Medicare, or Medicaid) are not eligible for MinnesotaCare. State officials have made no new or more accurate estimates of the target population for MinnesotaCare insurance since 1992. The 91,140 enrollees in MinnesotaCare as of October 21, 1995, represent less than 39% of the presumed uninsured persons, based on the most conservative estimate that 6% of Minnesotans are uninsured.[4] With no accurate baseline data, it is difficult to assess the program's success in providing coverage for the uninsured.

Since the proportion of uninsured is generally higher in rural areas, and previous research suggests that factors often associated with MinnesotaCare eligibility may be more common among rural populations (e.g., lower per capita income, less "discretionary" income, and higher unemployment), our study focuses on rural

Table 1

Expansion of MinnesotaCare eligibility

Beginning Date	Groups Eligible	Income Limit	Other Eligible Criteria	Cost to Enrollee
July 1, 1992	Children age 1 through 17	185% of the federal poverty guidelines	Not eligible for Medical Assistance (MA); not otherwise insured	Annual enrollment fee of $25 per person (up to $150 per family)
October 1, 1992	Children age 1 through 17; parents and dependent siblings	185% of the federal poverty guidelines	Not eligible for MA; not otherwise insured; permanent Minnesota resident	Adults pay premium based on sliding scale; children pay $25 enrollment fee until July 1, 1993*
January 1, 1993	Children under age 18; parents and dependent siblings	275% of the federal poverty guidelines	Not eligible for MA; no access to employer-subsidized coverage for 18 months; at least 4 months uninsured; permanent Minnesota resident	Premiums based on sliding scale
October 1, 1994	Single adults, families with or without children	275% of the federal poverty guidelines for families, 125% of the federal guidelines for single adults	Not eligible for MA; no access to employer-subsidized coverage for 18 months; at least 4 months uninsured; permanent Minnesota resident	Premiums based on sliding scale

Source: House Research Department, MnCare, Minnesota Legislature, St. Paul, Minnesota, October 1994 and written communication from Kathy Lamp, director, MinnesotaCare, February 1996.

*This applies to children in households with incomes under 185% of the federal poverty guidelines applying for coverage through June 30, 1993, and is contingent upon the availability of appropriations.

Minnesota.[5-8] But rural Minnesota is not homogenous. The populations of Minnesota's rural counties vary in age, income, employment, and race distribution. Diehr et al. found that a number of social and demographic factors were associated with different levels of state insurance program enrollment in Washington state, and it is likely such factors also affect rural enrollment in MinnesotaCare.[9] We must also consider other factors that might be uniquely associated with the accessibility of health services for rural citizens (such as distance to a metropolitan area and sparseness of the population), since persons with limited access to services may be less likely to purchase health insurance.

We present an initial assessment by county of MinnesotaCare penetration into the state's rural counties. Using a combination of county-level census data, vital statistics from the Minnesota Department of Health and Minnesota Department of Human Services, and the Area Resource File, we compare the number of MinnesotaCare enrollees with county population characteristics and a county "ruralness" score. In addition, we offer recommendations for identifying and collecting additional data that could further explain the variability of county-level enrollment in MinnesotaCare.

Methods

We listed Minnesota's rural counties and compared the number of enrollees in MinnesotaCare with the number of residents in the county under age 65 who reported incomes greater than 100% of the poverty level on the 1990 census (a proxy for those eligible for MinnesotaCare). People who are not eligible for MinnesotaCare are those over age 65, as well as those under 65 who have incomes less than 100% of the poverty level and are likely to be eligible for Medicaid or other state programs. While Medicaid has additional eligibility requirements, 100% of the poverty level is considered an ade

Table 2

Beale rural/urban continuum code

	Metropolitan Counties	
Large Metropolitan:		
0	Core Counties	Core counties of metropolitan areas of 1,000,000 or more population
1	Fringe Counties	Noncore counties of metropolitan areas of 1,000,000 or more population
2	***Medium Metropolitan***	Counties in metropolitan areas of 250,000 to 999,999 population
3	***Lesser Metropolitan***	Counties in metropolitan areas of less than 250,000
	Nonmetropolitan Counties	
Urbanized:		
4	Adjacent to metropolitan area	Counties contiguous to a metropolitan area and having 20,000 or more urban residents
5	Not adjacent to a metropolitan area	Counties not contiguous to a metropolitan area and having 20,000 or more urban residents
Less Urbanized:		
6	Adjacent to a metropolitan area	Counties contiguous to a metropolitan area and having 2,500 to 19,999 urban residents
7	Not adjacent to a metropolitan area	Counties not contiguous to a metropolitan area and having 2,500 to 19,999 urban resident
Thinly Populated:		
8	Adjacent to a metropolitan area	Counties contiguous to a metropolitan area and having less than 2,500 urban residents
9	Not adjacent to a metropolitan area	Counties not contiguous to a metropolitan area and having less than 2,500 urban residents

Source: Economic Research Service, U.S. Department of Agriculture.

quate proxy for Medicaid eligibility.[10] We ranked the counties from highest to lowest based on the percentage of county residents enrolled in MinnesotaCare.

To better understand the variability among counties in MinnesotaCare enrollment, we calculated partial correlation coefficients to compare each county's Minnesota-Care enrollment with relevant demographic and socioeconomic variables identified by researchers studying state-subsidized insurance programs.[9,11] These variables include county population density, unemployment rate, ruralness, percentage of eligible persons requesting and receiving Medicaid benefits, and racial mix. We used partial correlation coefficients to examine the influence of the different factors while controlling the effect of other variables.

Data for the study came from several sources. Data from the Minnesota Department of Health included the percentage of the population at or below 100% and 200% of the federal level for poverty.[1] We obtained information on the number of enrollees in MinnesotaCare and the number of Medicaid beneficiaries from the Minnesota Department of Human Services. The Area Resource File, compiled by the Bureau of Health Professions' Office of Research and Planning, provided information on the total population, the proportion of nonwhite individuals, the population density, the unemployment rate, and the population under age 65 by county.

We also used the 1988 rural/urban continuum scale, developed by the Department of Agriculture in our analysis (see Table 2). We used this variable to better quantify ruralness. Rural Minnesota counties are those not listed as part of a metropolitan area (MA) by the Federal Office of Management and Budget, plus six counties that are listed as metropolitan counties but have characteristics more in common with rural areas. The six counties include Clay, Houston, and Polk, which have no cities of greater than 5,000 residents but are adjacent to MAs in other states. These border counties appear to be rural when considering the MinnesotaCare program. In addition, Stearns, Benton, and St. Louis counties share an MA that is more than 60 miles from the majority of each county's land mass.

Results

MinnesotaCare enrollment in rural counties varies from a high of 10.8% of Red Lake County's population who are under age 65 and report incomes over 100% of the poverty level to a low of 1.5% in Nicollet County (see Table 3, pages 46-47). The figure maps enrollment variability. Counties with the lowest percentage of the population enrolled in MinnesotaCare are clustered in southern Minnesota, especially the southeastern counties. Those with higher enrollment appear to cluster in cen-

tral Minnesota. Three counties (Red Lake, Clearwater, and Aitkin) have over 10% of the target population enrolled in MinnesotaCare.

Table 4 (page 48) shows the partial correlation coefficients of MinnesotaCare enrollment with relevant socioeconomic and demographic variables identified by the health services literature. In rural Minnesota counties, increases in unemployment, the number of citizens under age 65 with incomes greater than 100% and less than 200% of the poverty level, and the number of persons receiving Medicaid all positively correlate with the level of MinnesotaCare enrollment. A higher level of ruralness is also associated with higher MinnesotaCare enrollment. However, having more nonwhite residents and lower population density are associated with lower county enrollment in MinnesotaCare. All of these partial correlations are statistically significant with a p-value of less than .05.

Discussion

Overall, enrollment in MinnesotaCare is less than 40% of the estimated uninsured population of Minnesota and varies widely from county to county, with a greater than sevenfold difference between the highest and lowest rural county enrollments. It is not possible to make a more specific assessment of MinnesotaCare penetration into rural counties since no measurements of the actual number of eligible residents exist. However, from our analysis, we can assess factors that are associated with higher levels of MinnesotaCare enrollment.

MinnesotaCare enrollment is positively correlated with the individual county's unemployment rate and the percentage of the county's population with incomes greater than 100% and less than 200% of poverty. Since MinnesotaCare eligibility requires having income levels less than 275% of the federal poverty guidelines, we anticipated this finding. It is also consistent with the findings of other studies of state-subsidized insurance programs.[8-10] As expected, a higher unemployment rate implies less access to employer-based insurance programs and greater MinnesotaCare enrollment.

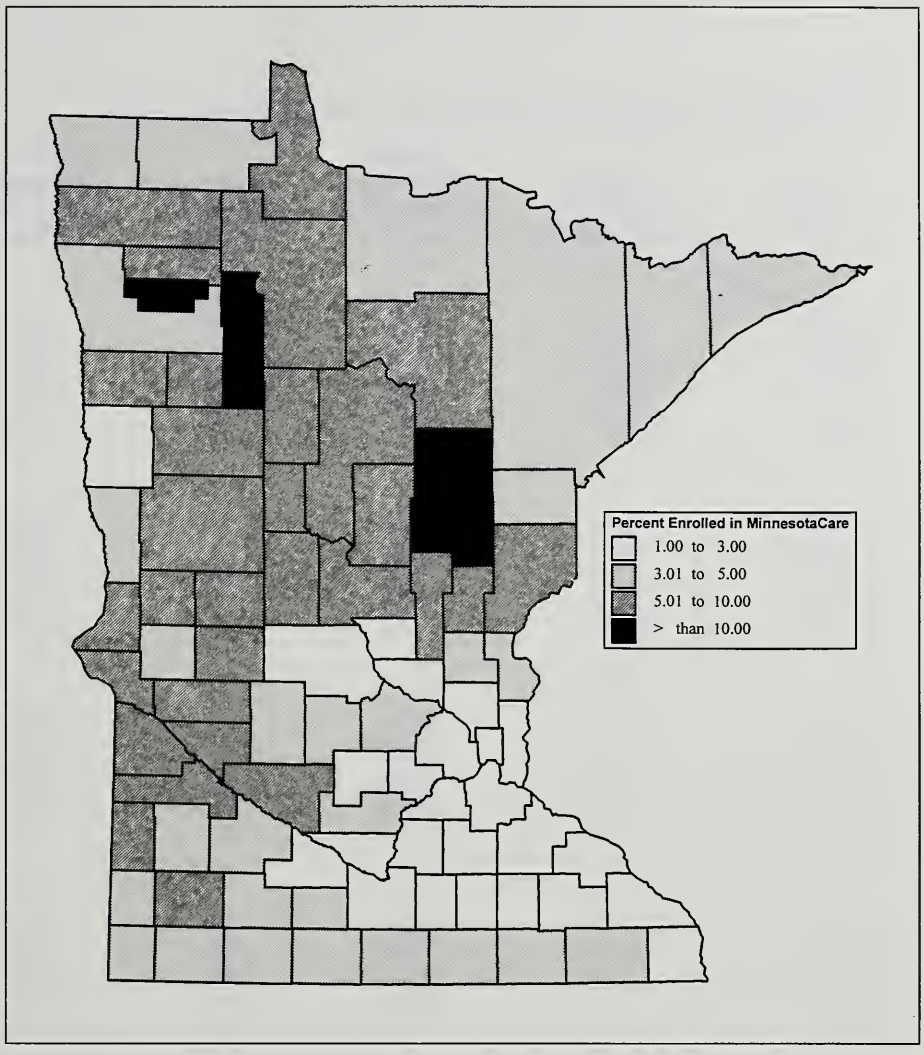


FIGURE —MinnesotaCare enrollment as a percent of county residents under age 65 with incomes greater than 100% of the poverty level.

The percent of the nonwhite population negatively correlates with MinnesotaCare enrollment. We did not anticipate this finding, which contradicts previous findings that an increase in the minority population resulted in an increase in enrollment in the state-subsidized insurance program.[9] Several explanations are possible, including the availability of Indian Health Service providers for Native Americans in rural counties and the high percentage of rural minorities who are recent immigrants and are currently receiving Medicaid benefits. While these may be plausible explanations, this finding deserves further evaluation.

The percentage of persons who receive Medicaid in each county positively correlates with MinnesotaCare enrollment. Since those eligible for Medicaid are not eligible for MinnesotaCare, we used this variable as a proxy for the populace's acceptance of state-subsidized insurance programs rather than as a proxy for income. Other researchers have found that communities less concerned with the stigma of accepting Medicaid may also be more willing to accept other subsidized programs.[7,10,11]

Both the population density and the ruralness of the county positively correlate with MinnesotaCare enrollment. Increased ruralness positively correlated with increased enrollment after adjusting for other factors, such as the county unemployment rate and poverty level. This suggests that other factors we did not consider in our analysis may be important, such as access to employer-based insur-

Table 3

Ranking of rural counties by MinnesotaCare enrollment rate

County	Percent Enrolled in MinnesotaCare*	Percent Receiving Medical Assistance	Percent Minority	Percent Under 200% of Poverty	Unemployment Rate	Population Density
Red Lake	10.76	22.02	1.10	56.33	15.4	10.45
Clearwater	10.55	38.21	7.77	62.68	17.0	8.32
Aitkin	10.49	33.39	1.86	64.48	11.3	6.77
Cass	9.72	36.06	11.39	61.93	9.6	10.72
Hubbard	9.71	29.03	2.02	52.49	9.4	15.96
Wadena	9.68	32.88	1.05	62.40	7.3	24.45
Big Stone	9.27	22.58	0.76	58.49	5.3	12.65
Lincoln	8.66	16.95	0.48	58.33	5.0	12.81
Traverse	8.35	27.09	3.18	56.85	5.6	7.76
Morrison	8.20	20.25	0.66	51.59	9.0	26.34
Swift	8.15	22.15	0.94	55.49	6.4	14.43
Becker	8.10	32.90	7.29	52.29	10.6	21.25
Norman	7.84	24.55	1.37	53.25	7.6	9.09
Pope	7.67	20.22	0.44	57.97	5.7	16.09
Lake of the Woods	7.48	17.08	0.83	47.95	6.1	3.15
Todd	7.44	22.69	0.56	59.87	8.2	24.83
Otter Tail	7.38	18.00	1.03	48.48	7.0	25.70
Grant	7.27	20.65	0.50	57.09	6.7	11.42
Marshall	6.77	15.39	0.95	50.11	12.7	6.25
Beltrami	6.71	34.43	17.38	53.20	7.8	13.72
Lac Qui Parle	6.68	15.78	0.64	52.88	4.9	11.56
Crow Wing	6.65	24.00	1.38	47.30	7.4	43.90
Itasca	6.46	27.30	3.68	45.53	10.8	15.36
Douglas	6.26	17.01	0.73	47.85	5.9	44.59
Pine	6.24	23.30	4.19	47.73	9.6	14.96
Yellow Medicine	5.87	19.30	1.61	50.59	5.5	15.41
Mahnomen	5.85	34.89	24.01	68.81	8.2	9.02
Chippewa	5.38	19.85	0.86	45.90	6.7	22.65
Kanabec	5.33	21.03	1.14	46.14	9.6	24.29
Mille Lacs	5.27	22.92	3.75	46.93	7.6	32.30
Murray	5.26	16.49	0.31	48.44	6.3	13.76
Pennington	5.21	23.04	1.55	45.79	8.8	21.53
Renville	5.18	24.47	1.42	46.45	5.9	17.96
Wilkin	5.00	21.67	1.20	47.04	4.5	10.01
Pipestone	4.95	17.11	2.34	50.82	5.0	22.51
Kandiyohi	4.91	24.80	2.38	40.70	5.2	49.44
Meeker	4.89	16.77	1.26	43.53	8.4	33.41
Cottonwood	4.85	16.12	1.03	48.59	7.3	19.83
Polk	4.82	35.00	3.07	45.76	5.5	16.40
Koochiching	4.67	18.28	4.09	44.18	9.7	5.24

Table 3 (continued)

County	Percent Enrolled in MinnesotaCare*	Percent Receiving Medical Assistance	Percent Minority	Percent Under 200% of Poverty	Unemployment Rate	Population Density
Redwood	4.44	15.37	2.20	49.16	4.4	19.5
Cook	4.30	13.12	7.70	40.59	6.2	2.74
Stevens	4.16	12.41	2.52	46.11	4.3	18.99
Fillmore	4.07	15.11	0.58	49.28	5.7	24.10
Kittson	3.96	16.65	0.61	46.46	7.7	5.22
Lake	3.91	16.85	0.80	42.04	9.4	5.07
Carlton	3.80	20.49	4.90	40.31	8.2	33.86
Rock	3.74	12.17	0.76	47.17	3.3	20.30
Lyon	3.68	14.56	1.47	38.50	3.9	34.72
Martin	3.62	16.36	0.87	42.42	5.8	32.46
Faribault	3.50	17.53	1.58	48.49	5.9	23.72
St. Louis	3.34	22.87	3.11	39.93	7.4	32.36
Freeborn	3.25	16.16	2.55	38.89	4.7	46.89
Nobles	3.18	16.07	3.44	44.56	4.4	28.15
Watonwan	3.14	19.01	4.81	45.92	4.9	26.86
Mower	3.14	18.58	1.32	40.11	3.9	52.58
Jackson	3.11	21.55	2.25	45.36	5.4	16.71
Roseau	3.11	10.22	1.68	40.64	4.9	8.96
Sibley	3.08	12.68	0.74	42.05	6.7	24.23
Dodge	2.82	14.38	1.28	31.91	6.0	35.83
Le Sueur	2.64	12.36	0.70	33.19	6.4	52.11
Clay	2.56	21.22	3.69	35.52	4.3	48.07
Wabasha	2.55	12.09	0.83	35.03	5.2	36.77
Benton	2.47	14.78	1.15	36.23	5.7	73.98
Rice	2.46	9.89	2.24	26.21	5.7	98.17
Blue Earth	2.27	13.08	2.58	40.96	3.8	72.15
Goodhue	2.26	11.63	1.45	30.09	4.3	53.33
Winona	2.26	10.91	1.96	36.48	5.2	75.92
Houston	2.26	11.95	0.72	37.19	5.6	32.80
Waseca	2.19	12.67	1.08	36.31	5.1	42.84
Brown	2.09	11.34	0.72	35.99	5.2	44.2
Stearns	2.02	9.81	1.46	34.93	5.1	88.78
McLeod	1.95	11.04	1.06	28.18	5.3	65.50
Steele	1.70	11.11	1.53	26.87	4.8	71.30
Nicollet	1.53	9.90	1.57	26.04	3.5	63.81

*This column compares the number of MinnesotaCare enrollees to the number of county residents under age 65 with incomes greater than 100% of the poverty level on the 1990 census. Only persons under age 65 are included in the percent receiving MA and the percent under 200% of poverty. The other columns present population characteristics as a percent of the total county population.

Table 4

The relationship of MinnesotaCare enrollment and county socioeconomic and demographic characteristics

(Rural counties only, n=75)

Variable	Pearson Partial Correlation Coefficient†	p-value
Percent of persons < 65 years who are receiving Medical Assistance	0.44	0.0001
Percent of nonwhite residents in county	-0.53	0.0001
Population density of the county in persons/square mile	0.25	0.0349
Percent of persons < 65 years whose yearly income is between 100% and 200% of the poverty level*	0.68	0.0001
Rural/urban continuum code	0.33	0.0053
Unemployment rate	0.46	0.0001

*Although MinnesotaCare eligibility is up to 275% of the poverty level, no county-level data are available from the U.S. Bureau of Census other than the percent of the population below 100% or 200% of the poverty level.

†The Pearson Partial Correlation Coefficient is a measure of the association of each variable with the factor of interest (percent of the community residents enrolled in MinnesotaCare), taking into account all of the other variables. The coefficient is positive when the association is positive, and negative when it is negative. In general, the larger the coefficient, either positive or negative, the greater the association.

ance, county methods of enrollment in MinnesotaCare, or the populace's perception of the accessibility of health care in more rural counties.

The clustering of lowest and highest enrollment in southeastern and central Minnesota, respectively, is interesting and deserves additional investigation. For example, information about the availability of employer-based insurance for those who are employed would be useful. If employers in southeastern Minnesota are more likely to provide or subsidize employee insurance, this could further explain the lower MinnesotaCare enrollment in this region.

County-level enrollment in MinnesotaCare depends on geographic and sociodemographic variables. However, we can change few of these variables easily. Instead, we must search for other more modifiable county or county-level program characteristics if we hope to improve the accessibility of MinnesotaCare. Studies of applicant-perceived barriers to other state-run programs (such as Medicaid) identify the following barriers to enrollment: length of the application form, access to application sites, personal pride, stigma associated with the program, program restrictions, prohibition of patient contributions for services, and attitudes of those conducting the enrollment process.[7,8,10,11]

The Minnesota Department of Human Services has developed and disseminated basic requirements for county administration of MinnesotaCare enrollment. However, counties continue to have great latitude in how they promote MinnesotaCare. Each county chooses how it advertises MinnesotaCare and educates the populace regarding available benefits. Each county chooses the number and location of enrollment sites. In addition, physicians and other providers in each county may have different levels of willingness to encourage MinnesotaCare participation.

Case studies of counties with high and low MinnesotaCare penetration could generate hypotheses about which of these factors is likely to be most important in explaining enrollment variation. Each case study should include a description of enrollment procedures, enrollment sites, and attitudes and workload of staff who complete enrollment procedures and reviews. Studies could also assess the outreach or collaborative activities of the county human service agency in assuring MinnesotaCare enrollment.

We cannot easily modify many of the factors—unemployment rates, population density, and ruralness of a county—associated with increased enrollment in state-subsidized insurance programs. Selected case studies would provide additional information on enrollment implementation and program administration procedures. These studies could also identify those community attitudes that could change, thereby enhancing rural enrollment in state-subsidized health insurance programs. MM

ACKNOWLEDGEMENT

Support for this paper was provided by the Office of Rural Health Policy, Health Resources and Services Administration, PHS Grant No. CSR 000003-03-0. The authors acknowledge the helpful comments of Kathy

Lamp, formerly of the Minnesota Department of Human Services, and Leeann Habte, of the Minnesota Department of Health, on an earlier draft of the paper.

Barbara Yawn is a family physician and a senior investigator at the University of Minnesota Rural Health Research Center. She is also the director of clinical research at the Olmsted Medical Center in Rochester, Minnesota. Sarah Krein is a research assistant at the University of Minnesota Rural Health Research Center.

REFERENCES

1. Winterbottom C, Liska D, Obermaier K. State-level databook on health care access and financing. Washington, D.C.: Urban Institute Press, 1995.
2. Frenzen P. Rural health insurance coverage in U.S. urban and rural areas. J Rural Health 1993;9:204-14.
3. Yawn B, Yawn R, Jacott W. MinnesotaCare (Healthright): myths and miracles. JAMA 1993;269:511-5.
4. Call K, Jonk Y, Feldman R, et al. Minnesota Health Care Insurance and Access Survey, 1995. Final Report. Institute for Health Services Research, University of Minnesota and Blue Cross and Blue Shield of Minnesota, Minneapolis, Minnesota. August 1996.
5. Hartley D, Quam L, Lurie N. Urban and rural differences in health insurance and access to care. J Rural Health 1994;10: 98-108.
6. Kralewski J, Liu Y, Shapiro J. A descriptive analysis of health insurance coverage among farm families in Minnesota. J Rural Health 1992;8:178-84.
7. Braden J, Beauregard K. Health status and access to care of rural and urban populations. AHCPR Pub. No. 94-0031. National Medical Expenditure Survey Research Findings 18. Rockville, Maryland: Agency for Health Care Policy and Research, U.S. Public Health Service, 1994.
8. Thomas K. Are subsidies enough to encourage the uninsured to purchase health insurance? An analysis of underlying behavior. Inquiry 1994;31:415-24.
9. Diehr P, Madden C, Martin D, et al. Who enrolled in a state program for the uninsured: was there adverse selection? Medical Care 1993;31:1093-1105.
10. Holahan J, Zedlewski S. Expanding Medicaid to cover uninsured Americans. Health Affairs 1991;10:46-61.
11. Nelson K, Larsen K, Lurie N, et al. Barriers to Medicaid enrollment in Minnesota: some implications for health system reform. JAMA 1994;272:746.

1-800-4-CANCER

Knowledge
It's Part of the Cure

Thanks to research, we now know much more about breast cancer and how to treat it. Today, most women with breast cancer who are diagnosed and treated early continue to lead active and vibrant lives. For current information on breast cancer, call the *National Cancer Institute's Cancer Information Service* at **1-800-4-CANCER**.



"The prospect of career challenges and growth without neglecting lifestyle is very appealing."
David Chen, M.D.

WASHINGTON

The Wenatchee Valley Clinic, a prominent 140+ physician, multi-specialty group practice in the Pacific Northwest has several practice opportunities throughout its practice locations. **Currently, we are seeking:**

WENATCHEE
- **Pediatrician**
- **Neurosurgeon**
- **Infectious Disease**
- **Cardiologist**
- **Pathologist**

OMAK/MOSES LAKE
- **Family Practice w/OB**
- **Obstetrician**
- **Ophthalmologist**
- **Urgent Care**
- **Dermatologist**
- **General Internist**
- **Gastroenterologist**

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Please send CV to James Brown, M.D. -

P.O. Box 489
Wenatchee, WA 98807
FAX (509) 664-7178

Wenatchee Valley Clinic

LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell
Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
or 800-295-6373
Fax: 682-4791

Thoracoscopic Sympathectomy for Palmar Hyperhidrosis

A Case Report

Patrick C. Graupman, Gaylan L. Rockswold, M.D., and David Blake, M.D.

ABSTRACT

Palmar hyperhidrosis is a disabling condition that manifests itself as excessive sweating of the hands. Although the exact cause is unknown, several medical and surgical therapies are available to treat it. Recent developments in surgical technique have made the less invasive thoracoscopic sympathectomy a viable alternative to the open sympathectomy for medically refractory cases. We believe that thoracoscopic sympathectomy is a safe and effective treatment for palmar hyperhidrosis.

Hyperhidrosis is a relatively common condition that manifests itself as excessive sweating of the hands, axillae, feet, and sometimes the entire body. Emotional factors often evoke the sweating. Hyperhidrosis, the etiology of which is unknown, can have devastating psychological, emotional, social, occupational, and economic consequences. Reports of suicide, depression, social withdrawal, and occupational hazards are not uncommon among sufferers.[1] Patients complain of smudging papers, staining clothes, being afraid to hold or shake hands, and being ridiculed. Occupational hazards range from workers being unable to grasp objects firmly to electricians receiving frequent shocks.[1,2] Studies have also shown that body areas affected by hyperhidrosis have chronic fungal infections.[3] This article discusses a typical presentation of hyperhidrosis and reviews its medical and surgical treatment.

Case Study

Patient history

A 30-year-old woman was admitted for surgery to correct a life-long history of hyperhidrosis of the hands and feet. As a child she feared square dancing in gym class because her partners would yell "ick," call her "clammy," and not want her to touch her hands. On the days that she knew she would have physical contact with other children in school, she would feign illness, hoping to stay home. When she was 9 years old, a physician told her to avoid using her hands in pottery because the clay caused redness and a fungal infection. As an adult, she worried about what people thought after they shook her hand. As a first-grade teacher, she noticed that her students avoided contact with her or winced when she held them.

Throughout the years, the patient saw dermatologists and many other physicians. They prescribed creams, ointments, and electronic devices, but none of the treatments offered relief. The patient had no other medical problems. A physical before surgery revealed only diffuse sweating of both palms and, to a lesser extent, both feet, during the exam.

Methods

On the day of admission, the patient was taken to the operating room and placed under general anesthesia. After creating an artificial pneumothorax, surgeons placed a camera and two trocars in the anterior, posterior, and mid-axillary line on the patient's right side. (Since the patient had no symptoms on her left side, she elected to have the procedure performed on the left side only if symptoms developed there.) The second, third, and fourth thoracic ganglia were identified, clipped, and confirmed by frozen section. Surgeons removed the instruments and inserted a chest tube. The patient had minimal blood loss and tolerated the procedure well. When she awakened, both her hands were warm and dry.

The following morning, the chest tube was removed, and the patient was discharged soon after. At two weeks, the patient still had dry hands bilaterally and a decrease in foot sweating. At two years, the patient reported being very satisfied with the results and said she would recommend the procedure to others. Although her right hand remained dry, symptoms developed in her left hand about two months after discharge; however, the symptoms were less severe and didn't bother her.

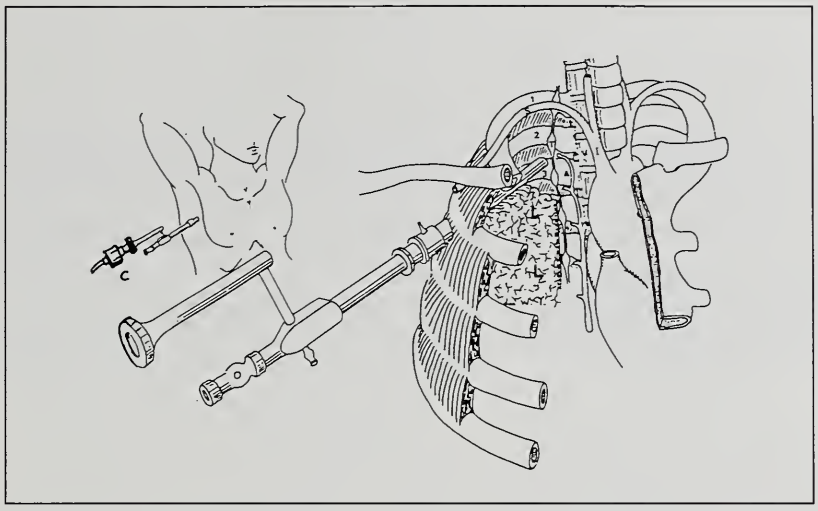
Discussion

The chief complaint of hyperhidrosis patients is excessive perspiration—not related to exercise or heat—symmetrically involving either the hands, feet, axillae, or some combination. One study found the affected areas to be confined to the hands in 40% of cases, in the hands and feet in 54%, while only 6% of patients had trouble with excessive perspiration elsewhere (chest, axillae, face, trunk).[2] Sixty-two percent of patients in another study had the condition since childhood, 30% since puberty, and 9% for less than one year.[4] Authors have reported that the prevalence of hyperhidrosis ranges from 0.6% to 1.0% in young adults.[5] Hyperhidrosis more commonly affects people of Eastern Asian descent, especially Japanese.[2,6] Family history is positive in 25% to 33% of individuals.[3,4,7] Sweating is often linked to a particular stimulus. Many patients say their symptoms are associated with an emotional stimulus, a thermal stimulus, or performing fine manual tasks; others cannot identify a link.[4,5]

Medical treatment

Many authors have found that medical therapy produces incomplete control or intolerable side effects.[1-3] Topical therapy (although lacking the side effects of systemic anticholinergic drugs like scopolamine and atropine) is impractical for hands. Topical agents like aluminum chloride hexahydrate (Drysol, Xerac) can also cause stinging, itching, burning, irritation, dermatitis, and open ulceration.

Iontophoresis using tap water may provide short-term relief of symptoms (up to one month) with a success rate of approximately 80%. Iontophoresis works by passing electrical current through the skin while it is immersed in a solution (in this case, tap water). The mechanism of action remains unknown. Initial therapy may take 30 minutes up to four times a week. Side effects are discomfort, burning and tingling, pacemaker interference, skin irritation, and iontophoretic burns and blisters.[8] Iontophoresis is not a permanent treatment.



FIGURE—Left: The patient's position when undergoing thoracoscopic sympathectomy. Right: The trajectory of the thoracoscope with the surrounding anatomic structures. 1, 2, 3, the upper three ribs; A, azygos vein draining from the costal vein; C, CCD camera; I, innominate artery; L, partially collapsed lung; S, subclavian artery; T, sympathetic trunk overlying the second rib neck; V, vertebral body. (Reprinted with permission from Kao M. Palmer hyperhidrosis in children: treatment with video endoscopic laser sympathectomy. J Pediatr Surg 1994;29: 387-91.)

Surgical treatment

Surgical options include open vs. thoracoscopic procedures. The open procedure requires a 10-cm vertical midline incision on the back to remove part of a rib and perform a transverse vertebral process. The hospital stay is typically about four days. Although this approach provides good exposure and good results, the closed thoracoscopic approach is rapidly replacing it.

Thoracoscopic sympathectomy has been done since 1954, when Mathias Kux developed and performed more than 1,400 thoracoscopic neurotomies in Europe.[1] During the 1960s and 1970s, the procedure fell out of favor for no known reason. It reemerged in the 1980s, in part because of the increasing use of endoscopy and outpatient surgery, and has been further refined using better instrumentation.

The procedure is relatively simple (see figure above). After creating an artificial pneumothorax, surgeons perform thoracoscopic sympathectomy through the mid-axillary line. The surgeon inserts the scope and, using a laser, either electrocauterizes or vaporizes the second through fourth thoracic sympathetic ganglia and trunk. Surgeons can monitor the success of the procedure intraoperatively using cutaneous temperature measurements of the hand. Almost immediately, the hand temperature increases 0.3°C to 5.3°C after removal of sympathetic innervation to the skin of the area.[3,6,9]

In several studies, about 98% of patients awakened from anesthesia reported warm and dry hands,[1,4,9-11] and 95% expressed initial satisfaction with the treatment.[1,4,9,12] Long-term followup showed a 1.5% recurrence rate for 270 patients, with a mean followup time of 14.6 years.[4] Other studies also showed the recurrence rate to be approximately 1% to 2%.[1,6,9,12]

The advantages of thoracoscopic sympathectomy over the open approach include smaller scars, less incisional pain, shorter hospital stays, decreased operating time, and lower morbidity and mortality rates. However, the surgery cannot be performed when patients have significant pleural adhesions, and bleeding is more difficult to control than in the open procedure.

The two most common side effects of thoracoscopic procedures are compensatory sweating and gustatory sweating. Compensatory sweating, which occurs on the chest, thighs,

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Internal Medicine
Occupational Health
Ob/Gyn

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES

"Central Washington isn't wet like Seattle. It's sunny and dry with many lakes and rivers. Orchards are everywhere."



Laurence Lee, M.D.

GASTROENTEROLOGIST

WASHINGTON - A unique opportunity now exists for a well-trained GI who has skills in therapeutic endoscopy. This new practice at our 19 provider multispecialty clinic in Moses Lake, Washington, has been developed as an outreach program from our central 140 physician group clinic in Wenatchee. Demand for services has reached the point to warrant a fulltime resident gastroenterologist.

The position entails full time GI and sharing endoscopy call with a general surgeon in this lake front community. The clinic has a recently completed ambulatory surgery and endoscopy center with video endoscopy. Samaritan Hospital, a 50 bed acute care hospital with well equipped ICU and endoscopy units, as well as a 24-hour staffed emergency department, is located less than a mile away.

Moses Lake, on the shores of a large recreational lake of the same name, is located in central Washington. The community, recently ranked among the top 100 smaller communities in the U.S., has a population of 15,000 with 60,000 in close proximity. The prospect for growth is excellent in part due to a desirable location with one of the largest airports in the state (site of a major airline pilot training facility) and convenient interstate highway access.

Abundant recreational opportunities exist on and around the lake as well as alpine skiing 65 miles away.

Please send CV to James Brown, M.D. -
P.O. Box 489
Wenatchee, WA 98807
FAX (509) 664-7178

Wenatchee Valley Clinic

back, and face, was seen in 48% to 70% of patients,[1,9] and gustatory sweating (facial sweating associated with eating) occurred in 3.2% to 51% of subjects.[1,4] Compensatory and gustatory sweating are thought to be a thermoregulatory response. The more sweat glands surgeons remove from neuronal control, the more likely sweating from the remaining innervated glands will occur.[2,4] As the body heats up, it has less surface area available to secrete sweat and, therefore, cool itself. Excising the second, third, and fourth thoracic sympathetic ganglia removes approximately one-fifth of the sweat glands from neuronal control; consequently, the remaining glands must work harder. Even after long-term followup, very few patients considered either of these two side effects more troublesome than the original condition.[1,2,3,4,7,12]

As a rule, compensatory hyperhidrosis and gustatory sweating decrease with time.[5,7] Another reported side effect of the surgery is incidental relief of concurrent hyperhidrosis of the feet. After the procedure, 64% to 82% of sufferers noted improvement or cure.[6,9]

One study asked patients whether they were satisfied with the results of thoracoscopic sympathectomy. Fifty-five of 59 patients (93.2%) thought that the surgery gave very satisfying results and had a positive impact on their life.[1]

Conclusion

Thoracoscopic sympathectomy is an effective, usually permanent, cure for hyperhidrosis. We believe that this procedure is the treatment of choice for patients not responding to medical management. MM

Patrick Graupman is a fourth-year medical student at the University of Minnesota. Gaylan Rockswold is chief of neurological surgery at Hennepin County Medical Center, professor of neurological surgery at the University of Minnesota, and a partner at Neurosurgical Associates, Ltd. David Blake is a partner at Cardiac Surgical Associates in the Twin Cities.

References

1. Kux M. Thoracic endoscopic sympathectomy in palmar and axillary hyperhidrosis. Arch Surg 1978;113:264-6.
2. Cloward RB. Hyperhidrosis. J Neurosurg 1969;30:545-50.
3. Kao M. Palmar hyperhidrosis in children: treatment with video endoscopic laser sympathectomy. J Pediatr Surg 1994;29:387-91.
4. Herbst F, Plaes EG, Fugger R, et al. Endoscopic thoracic sympathectomy for primary hyperhidrosis of the upper limbs: a critical analysis and long-term results of 480 operations. Ann Surg 1994;220:86-90.
5. Adar R, Kurchin A, Zweig A, et al. Palmar hyperhidrosis and its surgical treatment: a report of 100 cases. Ann Surg 1976;186:34-41.
6. Hsu C, Chen CY, Lin CT, et al. Video-assisted thoracoscopic T2 sympathectomy for hyperhidrosis palmaris. J Am Coll Surg 1994;179:59-64.
7. Drott C, Göthberg G, Claes G. Endoscopic procedures of the upper sympathetic chain: a review. Arch Surg 1993;128:237-41.
8. Reinauer S, Neusser A, Schauf G, et al. Iontophoresis with alternating current and direct current offset (AC/DC iontophoresis): a new approach for the treatment of hyperhidrosis. Br J Dermatol 1993;129:166-9.
9. Chen H, Shih D, Fung S. Transthoracic endoscopic sympathectomy in the treatment of palmar hyperhidrosis. Arch Surg 1994;129:630-3.
10. Claes G, Drott C. Hyperhidrosis. Lancet 1994;343:247-8.
11. Robertson DP, Simpson RK, Rose JE, et al. Video-assisted endoscopic thoracic ganglionectomy. J Neurosurg 1993;79:238-40.
12. Drott C, Göthberg G, Claes G. Endoscopic transthoracic sympathectomy: an efficient and safe method for the treatment of hyperhidrosis. J Am Acad Dermatol 1995;33:78-81.

Officers, Trustees, Directors Beware!

IRS-Imposed 'Intermediate' Sanctions Can Be Severe

Insiders in certain tax-exempt organizations can pay steep penalties for IRS-perceived compensation abuses.

Thomas J. Doyle, J.D.

For many years, tax law penalties have not affected persons who have a significant say in a tax-exempt organization's affairs when involved in wrongdoing related to the organization's exempt status. Instead, the penalty has been to revoke the organization's tax-exempt status. Recently, the IRS has been more assertive on the subject. The IRS found that certain practices in the health care industry—joint venture or other revenue-sharing arrangements, hospital or system purchases of physician practices, and compensation arrangements—may result in abuses by individuals. Yet the IRS had little recourse in tackling perceived abuses. The reason? The IRS was reluctant to punish a tax-exempt organization that benefited the community simply because insiders got more than they should have (or so the IRS might say) in one or a few isolated transactions.

So the IRS went to Congress, seeking a less draconian penalty for abusive transactions, one that would punish the actors instead of the organization. In 1996, Congress finally passed the Taxpayer Bill of Rights 2, which included intermediate sanctions.*

*See Section 501(c)(3) of the Internal Revenue Code of 1986, as amended. The IRC is Title 26 of the United States Code. It can be accessed on the Internet at http://www.law.cornell.edu/uscode/26/501.html.

Intermediate Sanctions

Under the new law, the IRS imposes intermediate sanctions on the person or persons dealing with 501(c)(3) or 501(c)(4) tax-exempt organizations in "excess benefit" transactions, and on the officers, directors, or trustees who approved the transactions.† The taxes imposed on both the "disqualified persons" and the "organization managers" can be steep. If an excess benefit transaction involves an "applicable tax-exempt organization," the IRS imposes a first-tier tax of 25 percent of the excess benefit on the disqualified person, and a tax of 10 percent of the excess benefit on the organization manager. If the excess benefit transaction is not corrected within a specified time frame, the disqualified person will be hit with a second-tier tax—a whopping 200 percent of the excess benefit.

Applicable tax-exempt organization

The intermediate sanctions law contains a number of bureaucratic-sounding terms. Let's review them one-by-one. First, the law only applies to transactions with an applicable tax-exempt organization (ATEO), as described in either Section 501(c)(3) or 501(c)(4) of the Internal Revenue Code. Most hospitals fall under this category, as do most fundraising and educational foundations in support of hospitals or health care systems. Some medical clinics, particularly those that are closely affiliated with health care systems, are 501(c)(3) organizations. HMOs may be 501(c)(3) or 501(c)(4) organizations. Certain other health care organizations may also qualify. Moreover, if an organization has had 501(c)(3) or 501(c)(4) status but loses it, intermediate sanctions still apply to excess benefit transactions for the next five years.

Excess benefit transaction

In an excess benefit transaction, an ATEO provides an economic benefit directly to or for a disqualified person, and the value provided by the organization exceeds the value that it receives in return. For example, an excess benefit transaction could occur if an ATEO pays too much for a physician's practice, or pays unreasonably high compensation for services provided, if the physician is a disqualified person. An excess benefit transaction also could occur if an ATEO provides that benefit indirectly by causing a taxable subsidiary to pay excessive compensation to someone the ATEO would consider a disqualified person.

Also, if particular payments to a

†IRC Section 4958, added by sections 1311-1314 of the Taxpayer Bill of Rights 2, Public Law 104-168. In addition to adding the intermediate sanctions law, the Taxpayer Bill of Rights 2 extended the prohibition on private inurement to 501(c)(3) and 501(c)(4) organizations and requires such organizations to report information with respect to excess benefit transactions.

disqualified person are found to be excessive because they are personal in nature, such as personal or spousal travel expenses, they cannot be justified retroactively as part of a total compensation package *unless* the ATEO clearly intended the payments, when made, to be compensation for services. A key factor in determining intention is whether the ATEO and the disqualified person reported the payments as compensation (on the ATEO's Form 990 and on the recipient's Form W-2 or 1099).

Disqualified person

A disqualified person is someone in a position to exercise substantial influence over the affairs of the ATEO when the excess benefit transaction occurs, or during the preceding five years. That person's spouse, ancestors, children, grandchildren, great-grandchildren and their spouses, as well as that person's siblings and their spouses also are disqualified persons. If the disqualified person owns more than 35 percent of a corporation, partnership, trust, or estate, these entities are also disqualified.

Organization manager

The organization manager who may be responsible for the 10 percent tax includes each officer, director, or trustee of the ATEO, or the individual with the power or responsibility of an officer, director, or trustee, who knowingly participates in the excess benefit transaction. This would include, for example, directors of an organization who approve unreasonably high compensation for a disqualified person.

In any excess benefit transaction, more than one disqualified person may be involved, and more than one organization manager may participate. In that case, all disqualified persons and all organization managers are jointly and separately responsible for the full tax on their group. The IRS capped the total tax an orga-

How to Protect Yourself

To protect yourself against intermediate sanctions, begin by analyzing your affiliations. Does an applicable tax-exempt organization consider you a disqualified person or an organization manager? Some tax-exempt organizations create one or more taxable subsidiaries. In the view of Congress, an individual can be an employee of a taxable subsidiary yet still exercise substantial influence over the tax-exempt parent organization. In that case, the tax-exempt parent would consider the individual a disqualified person. If you are a disqualified person, what business dealings do you, members of your family, and organizations in which you own more than 35 percent have with the 501(c)(3) or 501(c)(4) organization? Might any of those business relationships or contacts give rise to an excess benefit transaction? Note that intermediate sanctions generally apply to excess benefit transactions occurring on or after September 14, 1995, unless a contract that was binding on September 13, 1995, did not change thereafter.

If you are a director, officer, or trustee of a 501(c)(3) or 501(c)(4) organization, insist that the organization put procedures in place to guard against excess benefit transactions. Although the intermediate sanctions law provides no guidance on the matter, Congress spelled out some procedures in its explanation. Briefly, you can presume no excess benefit transaction occurs if: 1) a transaction is approved by a board or committee that is composed entirely of individuals who are unrelated to and not subject to the control of the disqualified person involved in a transaction; 2) that independent board or committee obtains and relies on appropriate comparable transactions data (independent survey data on compensation levels or independent valuations in connection with purchase transactions); and 3) that independent board or committee fully documents the bases for its determinations. The IRS could rebut that presumption only if it develops sufficient contrary evidence. If an organization doesn't have these procedures in place, the IRS will likely presume excess benefit transactions were made. In that case, the disqualified person and the organization manager would have to overcome the IRS' presumption.

If you are an organization manager, take a hard look at your organization's indemnification provisions. Would they cover the intermediate sanctions tax? If so, would the payment of that indemnification trigger yet another excess benefit transaction? Could the organization avoid that possibility by supplementing existing indemnification procedures? An organization might add a bylaw provision that authorizes an independent board or committee to decide indemnification issues and to decide whether an indemnification payment can be considered reasonable compensation (in which case indemnification will occur) or not (in which case indemnification will not occur).

If Minnesota corporate law compels indemnification, but federal tax law treats the indemnification itself as an excess benefit transaction, an organization's board of directors would be in a difficult position if faced with an indemnification claim by a past officer or director. The only way to avoid that situation is for the organization's articles of incorporation or bylaws to limit or prohibit indemnification in those circumstances.

–TJD

nization manager would pay for a single excess benefit transaction at $10,000. However, the IRS has no cap on the total tax on disqualified persons. Recall that disqualified persons are subject to a first-tier tax if the excess benefit transaction occurs. They are also subject to a second-tier tax of 200 percent if the transaction is not corrected within a specified period.

Making Amends

To correct an excess benefit transaction, the excess benefit must be undone to the extent possible. The disqualified person must place the ATEO in a financial position not worse than if that person had been dealing under the highest fiduciary standards. That may mean more than just repaying the excess benefit. It may mean paying profits that the disqualified person received as a result of the excess benefit transaction, or possibly even more than just profits.

To avoid the second-tier tax, the disqualified person must correct the excess benefit transaction *before* the IRS assesses the first-tier tax or mails a "notice of deficiency" for the first-tier tax, whichever occurs first. The notice of deficiency is a formal written statement of extra tax due, generally sent when an audit or a postaudit appeal within the IRS doesn't resolve the issue. If, during an audit, the IRS proposes imposing the first-tier tax and refuses to back down then or after an appeal, the disqualified person will be faced with a Hobson's choice. That person either can correct the disputed excess benefit before challenging the IRS in court, in order to remove the possibility of the 200 percent second-tier tax, or risk *both* the first-tier and second-tier tax by not correcting the disputed excess benefit.

When Intermediate Sanctions May Apply

Suppose you serve as chief of the medical staff and on the board of directors of a hospital or other ATEO. Now suppose the ATEO contracts with you to serve as the medical director of a department. You are to perform administrative responsibilities, for which you are paid a set monthly amount. Later, the IRS claims that 40 percent of your compensation is an excess benefit. If the IRS prevails, you personally will be responsible for a first-tier tax of 25 percent of that 40 percent. If the ATEO's board of directors approved the contract, the directors will be responsible, jointly and separately, for a separate first-tier tax of 10 percent of that 40 percent. The way the law reads, you could be liable not only as a disqualified person but also as one of the directors.

Furthermore, if you don't repay the full 40 percent of allegedly excessive compensation before the IRS assesses the first-tier tax or mails a notice of deficiency, you would then be liable for an additional tax of two times the 40 percent excessive compensation. Assuming both first-tier and second-tier taxes are imposed, you could be penalized for a total of 90 percent of the *total compensation* you received as medical director, *plus* your share of the tax imposed on the directors who approved the unreasonably high compensation.

Taxes are the direct costs of intermediate sanctions. If intermediate sanctions are imposed, you may well find yourself facing indirect costs as well. Indirect costs could include the fees of accountants or lawyers who represent you before the IRS and out-of-pocket and soft costs of your time and staff time in identifying, locating, and compiling pertinent data for the transaction in question. Moreover, if intermediate sanctions are imposed, the state attorney general's office could compel the disqualified person to return the excess benefit amount to the ATEO, at least if the ATEO is a Minnesota charitable organization. The attorney general oversees charitable organizations in Minnesota to ensure that charitable assets are used for charitable purposes. If the disqualified person must return the excess benefit, conceivably that person could pay a total of 335 percent of the excess benefit to the IRS and the organization. Even that figure could increase if the disqualified person is required to account for and pay lost profits or other amounts as well.

Source of Payment

Each disqualified person and organization manager subject to intermediate sanctions is personally responsible for paying the taxes. Under state law, Minnesota nonprofit corporations generally are obligated to indemnify directors, officers, and employees against legal liabilities. Certain prerequisites to obtaining indemnification might not be met in an excess benefit transaction. Moreover, the organization might have indemnification limits. However, even if under Minnesota corporate law the organization can or must indemnify a disqualified person or an organization manager for intermediate sanctions tax liability, Congress has indicated that the organization's payment of the tax liability could itself be an excess benefit transaction. Thus, the organization's payment of your tax could itself trigger further intermediate sanctions tax liability, unless the payment plus all other compensation to you during the same year as the payment qualifies as no more than reasonable compensation.

Depending on the circumstances, meeting the reasonable compensation standard might be impossible. Suppose, for example, the excess benefit transaction is a contract for services that ended after one year; the parties have no ongoing relationship. After the relationship ends, the IRS alleges that the contract constituted an excess benefit transaction. Presumably, no amount of compensation from the organization to the disqualified person could be reasonable for the year in which the tax must be paid, if no services are rendered in that year.

Summary

The IRS pushed for intermediate sanctions for some time. It now has them, and we should assume that it will use them. If you're an insider to a 501(c)(3) or 501(c)(4) organization who is compensated by or has business dealings with the organization, or if you are an officer, director, or trustee of such an organization, study the intermediate sanctions law and congressional comment on it. Think

through its possible applications and ramifications. With the assistance of legal counsel, you may also want to carefully review your organization's indemnification policies and understand how they relate to intermediate sanctions taxes. Finally, keep your ear to the ground for further IRS interpretations and application of this important new tax law. MM

The preceding general discussion is designed to alert the reader to intermediate sanctions issues. It is not legal advice and should not be relied upon as such.

Tom Doyle is a shareholder of Felhaber, Larson, Fenlon & Vogt, P.A. Part of his practice is in the health law area.



SKI CASCADE LODGE...

LOCATED IN THE HEART of the North Shore Cross Country Ski trail. Cascade Lodge has log cabins, fireplaces, some with whirlpools, rooms in the lodge and a great family restaurant. Cross country ski the miles and miles of groomed trails at Cascade or downhill ski at Lutsen Mt. Ask us about lodging for groups too.
Call or write us for reservations.
HC3 Box 445 Lutsen, MN 55612

AAA

CASCADE LODGE
218-387-1112 1-800-322-9543



Hands are not for hitting.

Domestic violence is preventable.

If someone is hurting you, call: 612/646-0994

Created by the Minnesota Coalition for Battered Women – 612/646-6177 V/TDD. MMA

First Call Physicians, Inc.
A Locum Tenens Service
500 Eighth Ave. S.
Buffalo, MN 55313

Clinics/Hospital | **Physicians**

Locums Coverage = Revenue

- Patients falling through the gaps?
- Physician burnout or illness?
- Shortage of physicians?

- Earn more with less time.
- No administrative headaches.
- Malpractice premium paid.

Experience, Service, Honesty
Call (metro) 682-3852
(toll free) 888-682-3852

(You'll be glad you did!)

URBAN MEDICINE

continued from page 13

tive family after high school. He was a gang member in Los Angeles and participated in drive-by shootings.

He recently returned to the Midwest seeking help for his addictions. During his visit home, arguments erupted and, because of his violent threats, his family obtained a restraining order against him. He now lives on the streets and is anxious about his unstable emotional state and his continued substance use. He spoke to me of "where it all went wrong ... and how to return to a normal life."

K.L. appears to feel tremendous remorse for past violent actions and displays a willingness to change the direction of his life. I'm optimistic that I can provide this young man the tools to help him recover. However, I'm discouraged to learn that because it's 8 p.m., the staff can't find him a shelter or detox bed for the night. We have no choice but to turn him out onto the streets. He must wait days to see a psychiatrist.

Over the weekend, I think about K.L. and the inadequacy of his care. How often, I wonder, are middle-aged men with chest pain and ST elevation turned away from emergency departments because of a short supply of tPA?

The first face I seen when I enter the clinic Tuesday is K.L.'s. He sits waiting to see the psychiatrist.

A LONG-TIME PATIENT of Dr. Rumsey's, S.S. is a white man in his mid-30s with a history of chronic alcohol abuse and a seizure disorder. He leads a transient lifestyle. Much of the time he hops trains across the country.

S.S. presented today for a refill of his medications. He tells us he had been sober for several months, but when he returned to binge drinking a couple weeks ago, he lost his temporary job. He feels it is time to move on and hopes to catch a train that night. He describes how his continued use of alcohol has disrupted a "steady" life. He wishes he were able to stay sober for more than six months at a time. Yet he refuses treatment or a 12-Step program.

Creative solutions for all your health law problems

LEONARD STREET AND DEINARD

Leonard, Street and Deinard
Suite 2300, 150 South Fifth Street, Minneapolis, Minnesota 55402

For information call
Daniel J. McInerney, Jr.
Chair of the firm's Health Law Group
(612) 335-1500

Quality legal representation and community service since 1922

ANOTHER PATIENT, C.S., is a Native American woman in her late 20s, my age. A victim of abusive relationships since childhood, she recently moved to St. Paul to flee an abusive boyfriend. The effects of his last brutal attack are still evident; bruises and cuts distort her face.

The clinic staff has had a hard time arranging safe housing for C.S. She has a history of poor compliance with shelter rules. After much pleading, the clinic nursing and social work staff secured her access to a women's shelter. Today, C.S. tells me she is banned from the shelter for failing to comply with curfew and other house rules. She is living on the street, sleeping in vacant buildings and eating at the DDC.

I am concerned for her personal safety. The clinic staff observes that her friends are likely to take advantage of her. They may steal her money and medications, or may involve her in violent or dangerous activities. She seems unable to reach out for the available resources, and she slips back into the vicious cycle of abuse. ... The little blue "Pharmacopoeia" in my pocket offers no remedies. Today, I offer my ear and my compassion.

I am rewarded by her continued connection to the clinic. As long as she returns, we are able to assist her.

My interaction with the DDC patients and health care providers has confirmed my commitment to working in urban medicine, but the challenges are great. The concentration of cultural, ethnic, and socioeconomic disparity inherent to urban communities creates a difficult environment for providing health care. Cultural diversity among patients and coworkers requires that health care providers be familiar with cultural and ethnic differences and sensitive to their effect on health and illness. Drug abuse, street and domestic violence, and poverty—especially prevalent in our inner cities—exacerbate the problems of delivering health care to people outside the mainstream. MM

Colleen Townsend, a fourth-year medical student at the University of Minnesota Medical School, is currently doing a rotation in Chile.

People and Places Making Medical News

People

InterAmerican Heart Foundation President

James H. Moller, M.D., Paul F. Dwan Professor of Pediatric Cardiology at the University of Minnesota Medical School and past president of the American Heart Association, has been elected president of the InterAmerican Heart Foundation. The foundation, a federation of 22 heart foundations in North and South America, promotes cardiovascular health.

HealthPartners New Finance VP

HealthPartners has hired **Greg Klugherz** as vice president of finance and chief financial officer of its St. Paul-Ramsey Medical Center, Ramsey Clinic Associates, and Ramsey Foundation.

Before joining HealthPartners, Klugherz served as a marketing manager for Lawson Software, where he marketed financial software to the health care industry. Klugherz has also served as the controller and treasury director at Methodist Hospital and HealthSystem Minnesota in Minneapolis.

HealthPartners Performance Awards

HealthPartners recently recognized several physicians and dentists for their excellent performance. **Avi Nahum, M.D., Ph.D.**, director of the medical intensive care unit at St. Paul-Ramsey Medical Center, earned the Dr. Robert Mulhausen Award for excellence in teaching and postgraduate education.

Patrick O'Connor, M.D., M.P.H., who works in HealthPartners research, received the Research Award for extraordinary achievement in the area of clinical research.

Award recipients for the Dr. Maurice Visscher Award were honored for their overall clinical excellence. In the primary care category, **Howard Stang, M.D.**, and **Robert Larson, M.D.**, both pediatricians at White Bear Lake Clinic, tied for the award. In the specialty care category, the award went to **Elmer Kasperson, M.D.**, a surgeon at St. Paul-Ramsey Medical Center. **Paul Kwon, D.D.S., Ph.D.**, oral surgeon at Riverside Dental Clinic, was the dental care category winner.

St. Paul Social Worker Inducted into Health Care Hall of Fame

Ida Maud Cannon, medical social work trailblazer and a founder of the American Association of Hospital Social Workers in 1918, will be posthumously inducted into the 1997 Health Care Hall of Fame. Cannon died in 1960 at age 83.

Formerly a visiting nurse for the St. Paul (Minnesota) Associated Charities and graduate of the Boston School for Social Workers, Cannon began to transform Massachusetts General Hospital's social work program into a national model, making social work an expected hospital service. She recognized that patients' health hinged not only on overcoming health problems but also on coping with community problems.

Places

St. Paul Mansion to Open as Children's Hospice

One of the first residential hospices for terminally ill children in the nation will open in St. Paul next year. The hospice, named Deva House, will occupy a Summit Avenue mansion once used as a retreat center and will offer short-term respite care for up to eight children at a time. **Mary Ann Boe**, whose 14-year-old son Deva died 10 years ago, is executive director, and **Cathi Churchill** is project development manager.

Deva House will receive some of its funding from fees paid by insurance companies and health plans. Reimbursements won't cover costs, but the balance will come from donations, not the families. Grants from the Minnesota Twins, the Timberwolves, and the Ronald McDonald House organization will provide partial support.

Mayo Expands Rochester Space

The Mayo Clinic has planned a number of construction projects, including an 11-story building in downtown Rochester, which may be used for cancer diagnosis and treatment, cardiac diseases, transplantation, vascular medicine, and treatment and diagnosis for neurological diseases.

The projects will add 850,000 square feet and will be funded by Mayo benefactors and capital reserves. Mayo did not release cost estimates for all the projects, but indicated that the first of five stages is expected to cost around $122 million.

Lutheran Care Center Opens in Renovated Devine Redeemer

Residents of HealthEast Bethesda Lutheran Care Center have moved into their new home in the renovated Divine Redeemer Hospital. The $3 million renovation of the former hospital building, begun a year ago, includes a total interior facelift, updating of existing mechanical functions to meet code, and modifications to the facility to meet special needs of nursing home residents.

The new facility has 117 licensed beds for residents with short- and long-term care needs. It also includes a large meeting space and HealthEast's Immediate Care Center.

HealthPartners Wins HERA Awards

HealthPartners recently won two HERA awards for outstanding achievements in improving women's and children's health outcomes. A gold HERA was awarded to HealthPartners' Mother-Baby Chemical Health program. The organization's Pediatric Immunization program received a silver HERA.

Inspired by the Greek goddess Hera, protector of women and childbirth, the awards are presented annually by Wyeth-Ayerst Healthcare Systems and the Zitter Group to payers, providers, and plans that have demonstrated the greatest improvement in the health of women and children.

Lake City Clinic Joins Mayo Health System

Mayo Health System has announced plans to acquire the five-physician Lake City Clinic this spring. The clinic's physicians and allied health staff will become employees of Lake City Clinic–Mayo Health System. The clinic will continue to provide a complete range of general health care services to patients in Lake City and the surrounding area and will work with Mayo Clinic to build a new outpatient clinic and add new services to improve care for patients.

Inpatient Physicians Association Formed

In response to the growth of inpatient medical practices around the country, the National Association of Inpatient Physicians has been created to distill the experiences of many into the best way to deliver high-quality and efficient care to the hospitalized patient. Target membership includes physicians who spend much of their time in inpatient medicine, or those who have hospital rotations for a few weeks at a time.

Interested physicians may contact **Winthrop Whitcomb, M.D.**, in Springfield Massachusetts, at 413/748-9321, or **John Nelson, M.D.**, in Gainesville, Florida, at 352/333-5113.

'U' to Introduce Alternative Therapies

The University of Minnesota plans to incorporate alternative medicine, including homeopathy and Chinese herbal medicine, into its research, education, and patient care. The proposal, worked out by a 45-member task force created last August by **Frank Cerra, M.D.**, provost of the university's Academic Health Center, may be the first of its kind in the United States.

The proposal calls for health science students to learn about a wide range of alternative therapies, such as acupuncture, chiropractic, and naturopathy. The university also plans to research the therapies to determine how—and if—they work. The proposal also recommends that medical students learn about the health care preferences of minority groups.

The task force was led by **Mary Jo Kreitzer, Ph.D., R.N.**, director of complementary medicine and spiritual care for the university, and **Greg Plotnikoff, M.D.**, assistant professor of medicine and pediatrics.

Socioeconomics

Upper Midwest VA Sees Small Budget Increase

The Veterans Administration has allocated only a 1.5 percent budget increase to hospitals in the Upper Midwest Network, which treats veterans in Minnesota, the Dakotas, and western Wisconsin. The VA's new budget allocation plan is shifting money from the Northeast, where patient numbers are decreasing, to the South, where numbers are increasing.

While the increase should not change medical care at the facilities, other changes in the health care delivery system will, according to **Robert Petzel, M.D.**, director of the VA's Upper Midwest Network. VA hospitals will emphasize outpatient services and ambulatory care over inpatient care, and veterans will receive more in-home health care assistance as an alternative to hospital stays. "There will be no change in quantity or quality of service," Petzel told the St. Paul *Pioneer Press*. (See related articles, "Embracing Change" and "The Changing Face of the Veterans Affairs Health Care System," in the February *Minnesota Medicine*.)

United HealthCare to Assume AARP Contract

United HealthCare Corp. has signed a contract to provide supplemental Medicare (Medigap) insurance to the 30 million members of AARP. The 10-year contract, which will go into effect January 1, 1998, will shift from Prudential Insurance Company of America to United. Prudential had the contract since 1981.

The AARP contract covered 5.1 million policyholders in 1996 and brought in $3.8 billion in revenues for Prudential. The contract will provide traditional fee-for-service insurance. United's enrollees in these plans are expected to more than double.

The Medigap insurance covers such services as vision exams and eyeglasses, hearing tests and hearing aids, homemaker services, routine dental services and dentures, and preventive care. Monthly premiums for Medigap plans range from $35 to $175, depending on how much they cover and the state where they're offered.

Lois Quam, key player in Minnesota's health care overhaul, is chief executive officer of United's new AARP division.

United HealthCare Reports Drop in Profits

Fourth-quarter profits for United HealthCare Corp. fell 13 percent, the Minnetonka-based company announced, citing the rising cost of treating patients, particularly with drugs, as the reason for the decline.

For the quarter ended December 31, the company reported net income of $95.1 million, compared with $13 million a year ago, which included a $96.9 million restructuring charge. Before that charge, profits from operations were $109.9 million.

Like many HMOs, United's premiums did not keep pace with costs. **William McGuire, M.D.**, United's chief executive officer (profiled on page 8), said the company expects enrollment to grow 15 percent to 20 percent in 1997 and commercial premiums to increase 5 percent during that same time period. He also anticipates lower selling and administrative costs in 1997.

Merger Off for Two Health Firms

The planned $80 million merger of Health Risk Management of Edina and Florida-based Health Plan Services Corp. has been called off by mutual agreement, the companies announced. Delayed approval from the Securities and Exchange Commission and slumping company stock prices prompted the move.

The two companies will continue to support each other's health care management services though a joint marketing agreement formed in September.

Rates, Trends, Data

State Heart Disease Death Rates Declining

Minnesota has one of the lowest rates of death by heart attack in the country, and experienced one of the largest declines per 100,000 population between 1990 and 1994, according to a study by the Centers for Disease Control and Prevention (CDC). The age-adjusted rate for heart attack deaths in Minnesota dropped 4.6 percent a year from 1990 to 1994. Only four other states—Alaska, Colorado, Montana, and Oregon—reported larger decreases. Nationwide, the average drop per year was 2.6 percent.

The CDC credited economics and education for improvements in heart health. **James Moller, M.D.**, past president of the American Heart Association and professor of pediatric cardiology at the University of Minnesota, said in a Twin Cities-based *Star Tribune* article that the state is benefiting from the antismoking movement and the promotion of heart-healthy diets and exercise.

Income, Education Affect State Death Rates

Low income, poor education, and living in an area with a declining population are the greatest risk factors for premature death in Minnesota, according to a study led by **Robert Tilden, Dr.P.H.**, an epidemiologist and researcher at the Duluth Clinic.

Tilden suggested that low-income people are likelier than the middle class to have poor health habits. Other studies have said that people with low incomes and poor education are more likely to smoke and be obese. He also indicated that people who have not completed ninth grade are more resistant than others to adopting healthy lifestyles.

For his study, Tilden used 1990 census data for Minnesota's 87 counties and the 1992 death statistics compiled by the Minnesota Center for Health Statistics. He found that 9,644 of the state's 34,979 deaths that year occurred among people ages 15 to 69. The average death rate per 100,000 for those 15 to 69 was 322. The lowest was 193.7 in Stevens County and the highest was 667.1 in Aitkin County. The major cause of those deaths was cardiovascular disease, for which smoking and obesity are risk factors.

Moderate Growth Predicted for 1997 State Health Care Costs

The relatively moderate pace of growth in employee health care costs for larger employers will continue in 1997, with an average overall increase for active employees of only 3 percent, compared with 4 percent in 1996, according to the Towers Perrin *1997 Health Care Cost Survey*. **Julie A. Darst**, a consultant with the firm, said the moderate growth reflected the ongoing shift toward managed health care delivery systems, greater competition, and low inflation.

The survey also anticipates an average 1997 increase in health care costs of 4 percent for retirees under age 65 and 7 percent for Medicare-eligible retirees (age 65 and older). "The cost increase for retirees age 65 and older is more than double that of last year," said Darst.

Innovations

Minnesota Performs First Transradial Angioplasty

A new, less invasive angioplasty procedure that involves threading the catheter through the radial artery rather than the femoral artery, was recently performed for the first time in Minnesota. **David Mathias, M.D.**, an interventional cardiologist in Milwaukee, taught the technique to **Mark Erhard, M.D.**, a staff cardiologist at St. Joseph Hospital in St. Paul. Mathis and Erhard successfully performed the procedure on three patients in February.

The technique offers advantages for patients, cardiologists, nurses, and health insurers. Unlike conventional angioplasty, which goes through the femoral artery in the groin and requires patients to lie flat in bed for up to eight hours afterward with a 5-pound weight on the incision to prevent bleeding, the new procedure takes only about an hour. The incision itself is about 80 percent smaller than the one made in the groin, virtually eliminating the risk of bleeding. Because the radial artery is one of two arteries that supply blood to the hand, the hand continues to receive ample blood supply even if the procedure causes a problem.

Nurses no longer have to hold steady pressure on the incision for 20 minutes, a requirement that has triggered carpal tunnel complaints. The transradial approach costs $1,500 less than a conventional angioplasty, which ranges from $6,000 to $8,000.

Schneider-Namic is the Plymouth-based company that manufactures a catheter used in the procedure.

Medical Research

'U' Researchers Find Infertility Gene

Men who are missing part of their Y chromosome can be infertile regardless of their sperm count, according to a study in the February 20 *New England Journal of Medicine* by researchers at the University of Minnesota. The study also indicated that if these men conceive using assisted reproduction, they will likely pass the same genetic deletion to their sons.

The research team, led by **Jon Pryor, M.D.**, associate professor of urologic surgery, and **Ken Roberts, M.D.**, assistant professor of urologic surgery, evaluated 200 infertile men and found that 7 percent were missing part of their Y chromosome, nine had severely decreased or absent sperm counts, four had only slightly decreased sperm counts, and one had normal sperm counts. Fertile men may have a Y chromosome deletion, but if a man has the deletion and is infertile, the deletion is the most likely cause of his infertility.

"Approximately half of the men who come into our clinic leave without a specific diagnosis," Pryor said. "This study furthers our ability to diagnose infertility, suggest assisted reproduction sooner, and save the couple money, time, and heartache."

The Perfect Fit...

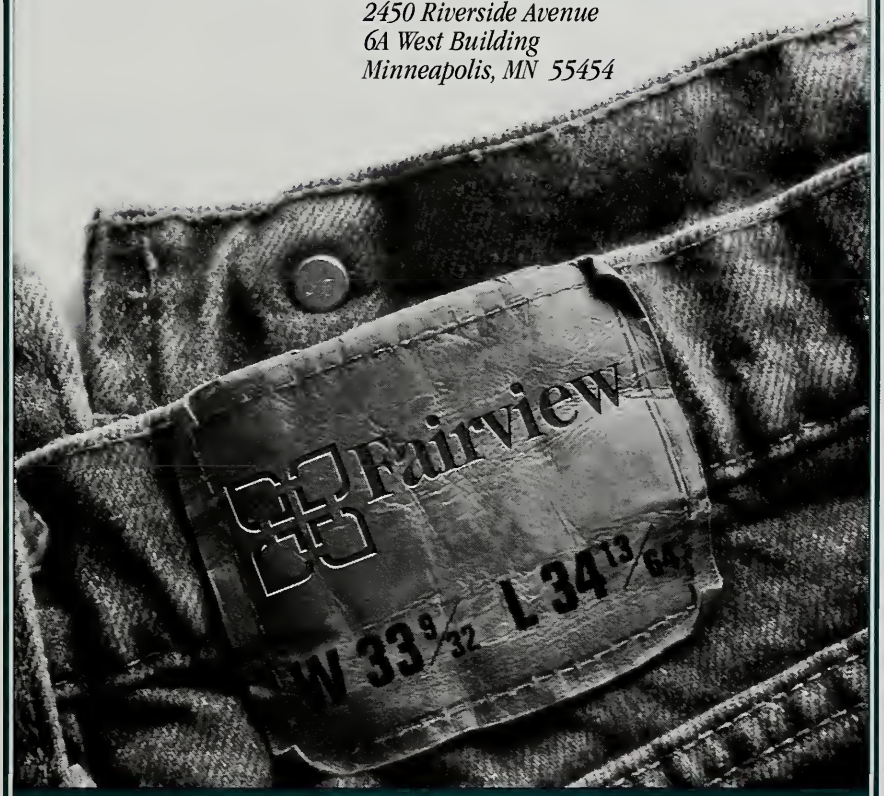
...is a rare find. Fairview Health System represents a wide spectrum of practice and lifestyle options in Minnesota. We will help you locate opportunities that are tailored to fit your needs in communities that match your size.

Opportunities now available in communities large, medium and small (and sizes in between) for...

- **Endocrinology**
- **Family Practice**
- **General Surgery**
- **Internal Medicine**
- **Obstetrics/Gynecology**
- **Orthopedic Surgery**
- **Urgent Care**
- **Urology**

Fairview

Physician Recruitment & Retention Dept.
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454



612-672-2288 or 1-800-842-6469 • E-mail: fhsrecruit@aol.com

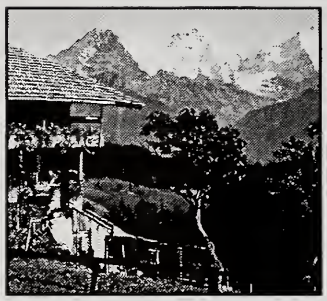
'U' Study Identifies Folate Requirements

Researchers at the University of Minnesota School of Public Health have identified the amounts of dietary folic acid (or folate), a B vitamin, that give women attempting pregnancy the best chance of preventing neural tube birth defects such as spina bifida. The study appeared in the February 19 *Journal of the American Medical Association.*

Previous research has shown that folic acid can prevent many neural tube defects. For optimal protection, women attempting

North Central Medical Conference

Presents Two Exciting Tours From Minneapolis/St. Paul



SWITZERLAND AND GERMANY

September 12-20, 1997

***$1,099* First Class Hotels**

Per person, double occupancy. (Plus government taxes.)

We invite you to experience the splendor of the Swiss Alps and a chance to sample the famous "Black Forest gateau!"

Optional Tours: Lucerne; Berne; Liechtenstein; Lake Constance; Zurich; Strasbourg; Freiburg and much more!



THE HIGHLIGHTS OF ITALY AND THE FRENCH RIVIERA

September 20-28, 1997

***$1,069* First Class Hotels**

***$1,119* Superior First Class Hotels**

Per person, double occupancy. (Plus government taxes.)

Chianciano Terme - A picturesque spa town situated between Florence and Rome.

Cannes - A city of glamour and movie stars.

Optional Tours: Rome; Florence; Siena; Pisa; Genoa; Monte Carlo; Nice, St. Paul de Vence and Grasse; and more!

Available to Members, Their Families and Friends.

For additional information and a color brochure contact:

GLOBAL HOLIDAYS

9725 Garfield Avenue South
Minneapolis, MN 55420-4240
(612) 948-8322
Toll Free: **1-800-842-9023**

INCLUDED FEATURES: Round trip transatlantic air transportation, seven nights accommodations, continental breakfast daily, all airline and hotel taxes, experienced escort guides and more!

pregnancy should have folic acid levels higher than 300 nanograms per milliliter in their red blood cells. In the current study, epidemiology professor **Judith Brown, Ph.D., M.P.H., R.D.**, studied 189 women in the Twin Cities who were trying to conceive. Women who consumed at least 450 micrograms of folate per day tended to have optimal red cell levels. However, 40 percent of the women had folate levels below 300 nanograms per milliliter, while one in eight had negative folate levels. "It's clear that most women cannot rely solely on their average daily diet to achieve the necessary folate levels," Brown said.

The Food and Drug Administration has ordered folic acid fortification of flour products beginning January 1, 1998.

Bone Cancers Command Osteoclasts to Self-Destruct

Cancer cells that originate in or spread to bone don't destroy the bone themselves but "command" bone cells to do it for them, according to researchers at the University of Minnesota Cancer Center. Cancer cells accomplish this by stimulating osteoclasts (large multinuclear cells in the marrow of growing bones) to carry out the destruction.

According to **Denis Clohisy, M.D.**, associate professor of orthopedics and member of the Cancer Center, about half of the 700,000 new cases of breast, prostate, lung, and kidney cancer diagnosed in the United States each year have skeletal metastases. When cancer spreads to bone, patients experience pain, immobility, and, ultimately, skeletal failure. "While there are no treatments to prevent tumor growth at the sites of bony tumor deposits, this finding is an important step toward developing ways to prevent bony tumor cell clusters from turning into problem tumors," said Clohisy.

Clohisy presented these findings in February at the American Academy of Orthopedic Surgeons annual meeting, where he received the Young Investigator Award for Research.

Study Reveals Breast Implant Problems

Nearly one-fourth of women who undergo breast implant surgery have complications that require a second operation within five years, according to a study by Mayo Clinic researchers that appeared in the March 6 *New England Journal of Medicine.* Women who had implants after mastectomies were nearly three times as likely to require additional surgeries than those who had implants for cosmetic reasons.

The most common complication was capsular contracture, a shrinking of the scar tissue around the saline or gel-filled implants. The contractures can cause pain and distort the shape of an implant, according to **Sherine Gabriel, M.D.**, a rheumatologist and epidemiologist who led the study. MM

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person..

APRIL 1997

Apr. 10-12 **Hip and Knee Reconstruction: Controversies and State-of-the-Art** Mayo Foundation; The Pointe Hilton at Squaw Peak, Phoenix, AZ. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 10-12 **Home Care Medical Directors Training Seminar II** University of Minnesota Continuing Medical Education; Surf and Sand Hotel, Laguna Beach, CA. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 11-12 **Annual Ophthalmology Course** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 17-18 **Research Statistics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Apr. 17-19 **Medical Directors Training Program** University of Minnesota Continuing Medical Education; The Historic Brown Palace Hotel, Denver, CO. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Apr. 17-19 **Spring Refresher** Minnesota Academy of Family Physicians; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Minnesota Academy of Family Physicians, 600 South Highway 169, Suite 1680, St. Louis Park, MN 55426; 612/542-0130 or 800/999-8198.

Apr. 24-25 **Broader Roles, Better Diabetes Care** International Diabetes Center; International Diabetes Center, Minneapolis, MN. CONTACT: Kay Martin, 3800 Park Nicollet Boulevard, Minneapolis, MN 55416; 612/993-2879.

Apr. 25 **Learning Disorders Assessment Program** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Apr. 28-May 2 **Family Practice Review Update 1997** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

MAY 1997

May 2 **Thirteenth Annual Heart Conference** St. Mary's–Duluth Clinic Health System; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Rockie Odberg, 400 East Third Street, Maildrop 5AVE2ME, Duluth, MN 55805; 218/725-3755.

May 2-3 **Cultural Diversity Conference** Hennepin County Medical Center; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

May 5-9 **Eighteenth Annual Practice of Internal Medicine** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

CONFERENCES

Apr. 9 **Emerging Infectious Diseases** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Emerging Infectious Diseases** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

May 6-9 **Fourth International Surgical Pathology Symposium** Mayo Medical Laboratories; Hotel Estoril Sol, Cascais, Portugal. CONTACT: Kathy Bates, Mayo Medical Laboratories, Office of Continuing Education, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

May 11 **Preventive Medicine** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 12-14 **Mayo Clinic Nicotine Dependence Seminar: Counselor Training and Program Development** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

May 16 **John I. Coe Symposium** Hennepin County Medical Center; St. Cloud Civic Center, St. Cloud, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

May 17 **Retinal Update: Laser Photocoagulation of Retinal Diseases** Phillips Eye Institute; Minneapolis, MN. CONTACT: Leslie Gibson, Phillips Eye Institute, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061; fax 612/870-0315; E-mail gibson@allina.com

May 20-21 **Advances in Inherited Urea-Cycle** University of Minnesota Continuing Medical Education; Hotel Schloss Wilhelminenberg, Vienna, Austria. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 21-23 **Current Concepts in Radiation Therapy** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 24-29 **American Academy of Physician Assistants' 25th Annual Conference** American Academy of Physician Assistants; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Sharon Kirksey, American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; 703/684-1924 ext. 3405.

May 29-June 1 **Workshops in Clinical Hypnosis: Introductory and Advanced** University of Minnesota Continuing Medical Education; Sheraton Inn–Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JUNE 1997

June 6-7 **Optimizing Disease Management Through Pulmonary and Gas Exchange Diagnostics** University of Minnesota Continuing Medical Education; Marquette Hotel, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 11-14 **Fiftieth Anniversary Mayo Interventional Cardiology Symposium** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

June 18-20 **Topics and Advances in Pediatrics** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

MMA-Accredited CME Sponsors

❧ The Minnesota Medical Association is the accrediting agency for Minnesota institutions that regularly sponsor continuing medical education activities for local physicians. ❧ Accreditation gives CME sponsors responsibility for conducting high-quality CME programs and for designating credit for CME activities. ❧ CME programs must comply with the MMA's "Essentials for the Accreditation of Sponsors of Continuing Medical Education" and the ACCME's "Standards for Commercial Support of CME" and "Standards for Enduring Materials." ❧

The MMA Committee on Accreditation and CME has recently reaccredited the following CME sponsors:

- ❧ HealthEast St. John's Hospital, Maplewood
- ❧ Olmsted Medical Center, Rochester

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800 DIAL-MMA.

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., April 15 for June ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

Olmsted Medical Center is seeking BC/BE physicians in family medicine. Great opportunity for well-trained physicians to join a 75-physician multispecialty group in a dynamic, progressive practice. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes 10 branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (5/96-R)

Rent Our Caribbean-Shore Home—Silver Sands, Jamaica. Cook, maid, your own pool. Sleeps eight. Great for families, groups. Rent from $1,995/week winter, $1,395 off-season. 800/260-1120. (10/96-R)

Fergus Falls Medical Group is expanding its 33-physician multispecialty clinic and is seeking physicians in the following specialties: dermatology, family practice, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (1/97-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice-trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Physician Needed to work part time in multidisciplinary clinic. All calls confidential to doctor's private line, 612/889-5973. (6/96-R)

Part-time Neurologist wanted for multidisciplinary office, no call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Urgent Care Physicians: We are a growing urgent care practice looking for BC/BE physicians to work full- or part-time to staff our four clinics. We currently have three locations in the metro area and one location in Mankato and are planning on expanding in 1997. Please contact Cara Auge at 612/593-9818 or 800/511-2820 for more information on joining our growing practice, or send inquiries to 9800 Shelard Parkway, #210, Plymouth, MN 55441. (4/97-R)

Family Physician—Parkview Medical Clinic in New Prague is recruiting. Rural town located 50 miles south of Minneapolis. Modern primary care hospital in town. New high school, community center, and fitness center. Two 18-hole golf courses. Strong industrial base. Highly desirable community. Excellent guaranteed salary. Contact: John Berg, M.D., 612/758-2535 (office) or 612/758-3000 (home) or write PO Box 186, New Prague, MN 56071. 2-4/97

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 25 member medical staff has openings in the areas of:

Family Medicine
Orthopedic Surgery
OB/GYN
General Surgery
Psychiatry
Podiatry

CHISAGO HEALTH SERVICES
A subsidiary of Fairview

Please contact:
Physician Recruitment and Retention Department
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454
1-800-842-6469

For Sale: Four-season cabin on Cross Lake (Whitefish chain). Excellent location, sandy beach, beautifully landscaped, low maintenance. Four bedrooms, three baths, 2,500 square feet; call 612/472-7884. 2-4/97

Luxurious geodesic home on secluded trout stream in Black Hills National Forest, South Dakota. Sleeps 10-12. Fully equipped kitchen, $700 a week. Call 320/274-5219 or 320/274-5113. 2-5/97

Multiple Family Practice opportunities in Iowa and Illinois private practice groups (one with a Christian philosophy). Good call coverage. Ob/gyn optional. New or renovated facilities; well-trained, congenial colleagues; competitive compensation with bonuses and loan repayment in some; professional management. Located in university towns and small metropolitan areas with excellent schools, low crime rates, and low cost of living. If you are considering the Midwest for an outstanding quality of life and practice, please call to discuss our many excellent options. Melissa McMurray, 800/546-0954, ID#4761MM, or fax 314/726-3009. 1-4/97

Urgent Care Physicians: Opportunities for BC/BE family practitioners. St. Francis Medical Center in Shakopee, 30 minutes southwest of Minneapolis, is opening an urgent care at the hospital in May 1997. Evening and weekend hours are available for permanent positions or moonlighting. A second location in Chaska, 10 minutes northwest of

Neurologist, Oncologist, Urgent Care

There are immediate openings at Brainerd Medical Center for a Neurologist, an Oncologist, and an Urgent Care physician.

Brainerd Medical Center, P.A.
- 35-Physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162 bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota
- Surrounded by the premier lakes of Minnesota
- Located in central Minnesota less than 2 1/2 hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:
- Curt Nielson
  (218) 828-7105
  or (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142

E-Mail: stephanie.l.jussila@qm.healthpartners.com

Central Minnesota Group Health Plan
HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220

Shakopee, is opening August 1997. Paid malpractice. Contact Debbie Modder, Allina Health System, Route 81465, 5601 Smetana Drive, Minnetonka, MN 55343; 612/992-3094 or 800/248-4921. 4-7/97

Practice to Take Over: Well-established internal medicine practice in downtown Minneapolis. Large patient base. Well-equipped for internal medicine. COLA certified laboratory. In-office computerized billing system. Nominal charge for equipment and goodwill. The incoming physician is expected to be busy from day one. Ideal for new residency graduate who has an ambition to be independent or to start own group. Will introduce. Forward all inquiries to: Minnesota Medical Association, Box 864, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. 4-7/97

Family Practice: Primary care with a personal touch—that's Regina Medical Group. Our well-established group has an opportunity for a BC/BE FP with a committed, community-based practice approach to join our Hastings, Minnesota, or Prescott, Wisconsin, sites. Excellent call, salary, and benefits. Forward your CV to Mark Kapler, vice president, Regina Medical Group, 1175 Nininger Road, Hastings, MN 55033; 612/480-4219. 3-4/97

Urgent Care

HealthPartners is an organization committed to preventive medicine, health promotion and high quality health care. We are seeking BC/BE Family Practice, and Internal Medicine and Pediatric physicians to work evenings and weekends at our Urgent Care clinics.

The Urgent Care clinics are supported by a 24-hour CareLine that is staffed with specially trained registered nurses. These nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic, which are located in Apple Valley, Brooklyn Center, Minneapolis, St. Paul and Woodbury. Physician staffing is based upon specific clinic needs and qualified physicians receive an excellent hourly salary and paid malpractice.

For more information on these positions, please call Laura Gaylord at (612) 883-5453 or send/fax your CV to HealthPartners, Physician Services, 8100 34th Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309, FAX: (612) 883-5395. You may also e-mail inquiries to: laura.j.gaylord@healthpartners.com. EO/AA Employer.

HealthPartners

HealthPartners' mission is to improve the health of our members and our community

---



ALEXANDRIA CLINIC, P.A.

The Alexandria Clinic, P.A., is a 30-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- PEDIATRICS
- NEUROLOGY
- INTERNAL MEDICINE/PULMONOLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

FAMILY PRACTITIONERS

Gundersen Clinic, Ltd., is seeking two BC/BE Family Practitioners to join our practice in the picturesque hills of northeast Iowa. West Union is part of Gundersen's regional rural network, a system staffed primarily with Family Physicians. The regional network is supported by both on-site and immediate phone consultative services (Medlink) from the 300-plus multi-specialty physician group in La Crosse, Wisconsin.

The West Union practice includes six community clinics, with the hospital and main practice located in West Union. The practice currently includes five Physicians (including a General Surgeon) and four Physician Assistants. Obstetric practice is highly desirable. Call is 1:4. Gundersen Clinic offers competitive salaries and excellent fringe benefits.

If you are looking for a practice that has all the positives of rural life, coupled with the strengths and support of a large multi-specialty teaching institution, please send letter of application and Curriculum Vitae to Frank Perez-Guerra, Manager, Recruitment, Retention and Resource Planning, Gundersen Clinic, Ltd., 1836 South Avenue, La Crosse, Wisconsin 54601; or call 1-800-362-9567, extension 6325.

Gundersen Lutheran
Care for the way you live.

Equal Opportunity Employer

PHYSICIAN
INTERNAL MEDICINE

Move to St. Cloud, Minnesota and join the Internal Medicine practice of *WARREN H. LUEDTKE, M.D.* He is the sole physician in a well-established, independent clinic. Specialties of the practice include *INTERNAL MEDICINE AND PRIMARY CARE.*

Dr. Luedtke is a Member of The Minnesota Clinic, Central Minnesota's only physician owned and governed medical delivery system. The Minnesota Clinic exists to continue cost effective, quality health care through the private practice of medicine.

Consider the benefits of a well-established practice and the pleasures and practicalities of life in a small city on the Mississippi, flourishing with cultural, civic and family activities.

TO FURTHER EXPLORE A GREAT MOVE, CALL:

WARREN H. LUEDTKE, M.D.
108 DOCTOR'S PARK
ST. CLOUD, MN 56303
(320) 255-1799

MEMBER OF THE Minnesota CLINIC
Your Partner in Quality Health Care

Suburban Family Practice Opportunity

Our HealthPartners' Bloomington Clinic offers family practitioners the opportunity to practice primarily adult medicine in a team oriented atmosphere. We currently have a full time opening combining trauma, orthopedics and sports medicine in an ambulatory setting.

To learn more, contact Lori Fake at (612) 883-5337, (800) 472-4695 or via e-mail: lori.m.fake@healthpartners.com. For consideration, forward your CV to: HealthPartners, Physician Services, P.O. Box 1309, Minneapolis, MN 55440. EO/AA Employer

HealthPartners

HealthPartners' mission is to improve the health of our members and our community

APRIL 1997 INDEX TO ADVERTISERS

Acute Care Inc. 24
Affiliated Community Medical Centers 26
Air Force Health Professionals–Ft. Snelling 25
Alexandria Clinic, P.A. 67
Allina 5
Aspen Medical Group 7
Brainerd Medical Center 66
Cascade Lodge 56
Central Minnesota Group Health Plan 66
Chisago Health Services 66
Fairview Clinic Services 61
First Call Physicians, Inc. 56
Global Holidays 62
Gundersen Clinic, Ltd. 67
HealthPartners 67, 68
Hennepin Medical Society 19
Leonard, Street & Deinard 57
Medical Protective Company ..... Cover 2
Midwest Medical Insurance Co. 3
Mitchell Clinic 30
Minnesota Clinic 68
MMBR ..... 32, 41, Cover 3
Mork Clinic, P.A. 26
Multicare Associates of the Twin Cities 52
North Memorial Medical Programs 20
St. Mary's/Duluth Clinic Health System 31
St. Paul-Ramsey CME 20
Staff Care, Inc. 31
Stillwater Medical Group 30
Stutzman-Helling 11
THC Minneapolis 5
University of Minnesota ..... 26, Cover 4
Wenatchee Valley Clinic 49, 52
Whitesell Medical Locums, Ltd. 49

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

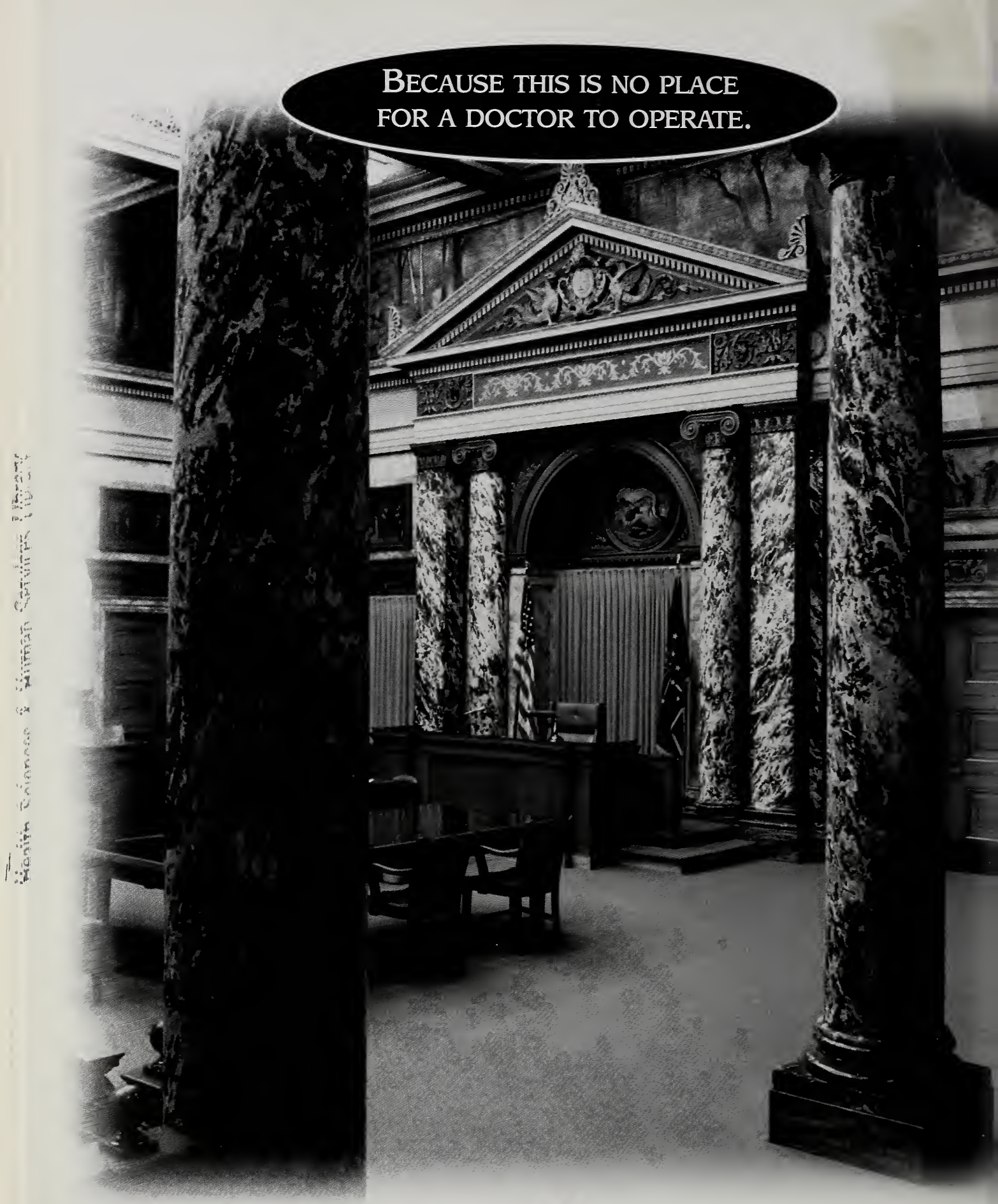


HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE
STACKS MAY 21 1997
REC'D NOT IN CIRC.

Univ. of Maryland
Health Sciences Lib.
111 S. Greene St
Baltimore, MD 21201-1583

Introspection in the House of Medicine

MAY 1997



THE
MEDICAL PROTECTIVE COMPANY®

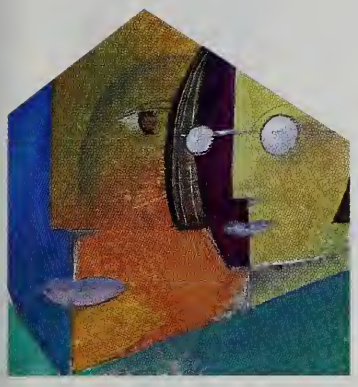
Professional Protection Exclusively since 1899

To reach your local office, call 800-344-1899.

GOLD CORPORATE AFFILIATE
MGMA
FOUNDED 1926
PROGRAM UNDERWRITER

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Andrew Powell.

DEPARTMENTS

2 ..... Editor's Notebook

6 ..... HealthScene Minnesota

41 .... Author Instructions

53 .... News Clips

59 .... CME in Minnesota

61 .... Classified Ads

64 .... Index to Advertisers

FACE TO FACE

8 **MMA's Chief Doctor** ..... Lorrie Holmgren

No stranger to change, MMA CEO Paul Sanders, M.D., says his main job is helping physicians take a leadership role in Minnesota's evolving health care system.

COVER STORY

12 **Introspection in the House of Medicine** ..... Howard Bell

Organized medicine is taking a good, hard look at how it meets physicians' diverse and ever-changing needs.

SPECIAL REPORT

19 **Physicians Give MMA High Ratings** ..... Stephen Dombrosk

MMA members are highly satisfied with the association, but that doesn't mean MMA leaders are feeling self-satisfied.

FEATURE STORY

22 **Gillette Children's Specialty Healthcare: For Kids' Sake** ..... Jeremiah Christopher Whitten

For a century, Gillette has stayed true to its mission: helping children with long-term disabilities and their families gain greater independence and enjoyment in life.

PUBLIC HEALTH REPORT

26 **Alcohol Use in Minnesota: Extent and Cost** ..... Doreen Kloehn, M.A., Kimberly J. Miner, Ph.D., Don Bishop, Ph.D., and Kathy Daly, Ph.D.

Physicians can be a major positive force in preventing and treating alcohol misuse, a widespread problem with alarming social and economic costs.

CLINICAL & HEALTH AFFAIRS

42 **Seizures and Spells: Physician Awareness of Minnesota Driving Laws** ..... Kathryn K. Selmo, M.D., Donald S. Asp., M.D., and David C. Anderson, M.D.

MEDICINE LAW & POLICY

49 **Is Direct Contracting the Business of Insurance?** ..... Margo S. Struthers, J.D., and Paul D. Anderson, J.D.

Recent regulatory pronouncements fail to clarify when health care provider risk sharing will be regulated as insurance.

33 The Monitor

Highlights..... *MMA launches grassroots effort to repeal 2% tax • Legislative update • Viewpoint: MMA strives for fair Medicare reimbursement*

Professional Solidarity

The AMA is 150 years old this year. The AFL-CIO is 116. Despite their disparate political agendas, these organizations have a common problem—they're shrinking. Like the labor movement, declining since the 1950s, the AMA and organized medicine at all levels have struggled in the last 10 years to maintain membership and clout. This month's *Minnesota Medicine* examines organized medicine and what it's doing to avoid the fate of the Gompers gang.



"Organized medicine's doctor audience is now a confusing pastiche of interests and needs."

Organized labor has faced the familiar "old dog, new tricks" dilemma. The old tricks of a crippling strike worked well in a blue collar-dominated economy. But as industry moved from production to service and workers from manual labor to knowledge-based jobs, unions faded in importance, shrinking from two-fifths to one-fifth of the labor force. In recent years, organized medicine has seen similar erosion in membership. Once claiming 80 percent of U.S. physicians as members, the AMA for years has signed up only about 42 percent of the nation's doctors. State and county society rolls have plateaued or declined. The colossus of organized medicine seems to be moving from the needed and heeded to the extraneous and ignored.

As noted in our cover story (page 12), the pathogenesis of this atrophy lies in demographics and economics. Today's physician workforce is more employed, more female, more free-time-ophilic. The employed look to their employers to represent them with big organizations or government. More time for recreating, child-rearing, or living a balanced life means less time for the committee work needed to power the traditional medical society. Economic threats have splintered previous professional solidarity, pitting specialist against generalist and bolstering the importance of specialty societies. New health care "team" members, like nurse practitioners, have taken over roles previously reserved for MDs.

Clearly, a physician is not a physician is not a physician. Organized medicine's homogeneous doctor audience of the '50s and '60s is now a confusing pastiche of interests, needs, and limitations that political economist Uwe Reinhardt has compared to Yugoslavia. Organized medicine is trying to figure out how to woo and win this polyglot. The AMA announced an "all-out" membership drive in 1996 with a campaign emphasizing professionalism. The Hennepin Medical Society launched its "First a Physician" campaign. A glimpse of the Minnesota Medical Association's tactics is found in our profile of MMA CEO Paul Sanders, M.D. (page 8), and in a summary of a recently conducted MMA survey of members and nonmembers (page 19).

The MMA survey results proclaim loudly that physicians want the MMA to continue its legislative advocacy. But the benefits of membership come with a price. Whether the future MMA, and all organized medicine, will be a good dollar value depends not only on the dues but also on how medical societies select their fights. The battles medical societies choose will shape their future image. And, as Andre Agassi says in the Canon commercial, "Image is everything."

Organized medicine has to remold its image as a bastion of defensive docs continually trying to return to the good old days of pure fee-for-service. Managed care is here, along with many other changes. The challenge for organized medicine and the profession is to make modern medical practice work for patient, doctor, and the system.

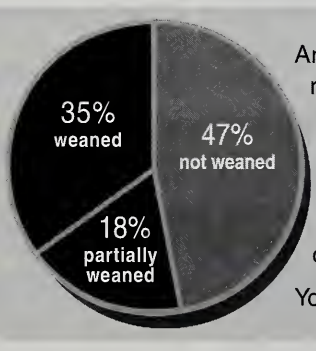
New worlds demand new tricks. Organized labor is exploring alternatives to rancorous strikes. Organized medicine is reworking its "tricks" by going back to the core professional ideals that define what it means to be a doctor. That's the only way organized medicine will be able to unify its Balkan states.

–Charles R. Meyer, M.D., Editor-in-Chief



More than 1/2 of our respiratory patients are freed from ventilator dependency.

We specialize in weaning the "unweanable." With aggressive therapies, dedicated staff, and advanced techniques, our Prolonged Respiratory Care Unit (PRCU) has successfully treated the nation's most difficult respiratory cases.



And we have helped 47% of our respiratory patients go home or to home care with most cases discharged in under 28 days.

So when you need respiratory care experts you can count on, call us.

You've got our number.

Call for your free outcome report

HealthEast Bethesda Lutheran Hospital & Rehabilitation Center

559 Capitol Boulevard St. Paul, MN 55103

1-800-566-2720

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Consulting Editors
Lenore Franzen
Susan Rodsjo

Assistant Editor
Juliet Ramotar

Public Health Reports Editor
Barbara P. Yawn, M.D., M.Sc.

Graphic Designer
Susan Rodsjo

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine.* The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/DIAL MMA (342-5662).

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine.* Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1996-97 Officers

President
Raymond G. Christensen, M.D.

President-Elect
Kent S. Wilson, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Paul R. Hamann, M.D.

Secretary
Judith F. Shank, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Anthony C. Jaspers, M.D.

Vice Speaker of the House
Blanton Bessinger, M.D.

Past President
Michael J. Murray, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Trinky Pollard

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth Crabb, M.D.
Theodore L. Fritsche, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/DIAL MMA (342-5662).

Fax: 612/378-3875.

E-mail: mma@mnmed.org

Web site: www.mnmed.org

CONTINUING MEDICAL EDUCATION

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

APRIL, 1997

19 URODYNAMICS
Presented by: Abbott Northwestern Hospital
Location: Abbott Northwestern Hospital, Minneapolis

MAY, 1997

1 PRINCIPLES OF DIABETES
Presented by: Allina Health System
Location: Mercy Hospital, Coon Rapids

2 NEW FRONTIERS IN THE MANAGEMENT OF ACUTE ISCHEMIC STROKE
Presented by: Minnesota Stroke Association and Noran Neurological Clinic
Location: Abbott Northwestern Hospital, Minneapolis

14 HEALTH CARE FOR THE UNDERSERVED
Presented by: United Family Health Center
Location: United Hospital, St. Paul

17 RETINAL COURSE
Presented by: Phillips Eye Institute
Location: Phillips Eye Institute, Minneapolis

JUNE, 1997

19 MINIMALLY INVASIVE CARDIAC SURGERY
Presented by: Minneapolis Heart Institute Found.
Location: Hyatt Regency Hotel, Minneapolis

For more information, contact the Allina Office of Clinical Education - (612) 992-2424

™ A Trademark of Allina Health System

Visit the Allina CME calendar on our Home Page at http://www.allina.com

SPECIAL CARE
FOR SPECIAL PATIENTS



Recovery from an illness, accident or injury requires experienced medical professionals, state of the art equipment and technologically advanced therapies. It also requires a comforting, nurturing staff, a "home away from home" environment and family involvement in patient care. Our hospital is dedicated to the recovery of critically ill patients. And we're with you every step of the way, with cost effective care that includes:

- *Pulmonary/Ventilator Program*
- *Wound Care Program*
- *Medically Complex Program*
- *Low Tolerance Rehabilitation Services*
- *Early Cognitive Recovery Program*

THC · Minneapolis...dedicated to returning each patient to the most productive life possible.

THC
Minneapolis
A Subsidiary of Transitional Hospitals Corporation

612-588-2750



Freedom of Choice ... at a Price

You step up to the health plan lunch counter and the server asks, "What will you have today, choice of physicians or lower premiums?"

In the past, the tradeoff was clear: you could select an HMO that offered access to a wide choice of providers, or you could save money by signing up with one of the "classic" HMOs that limited you to a much smaller panel of employed or contracted physicians. Today, it seems that all health plans promote themselves as offering broad choice. But do they?

In the 1980s, Physicians Health Plan (now Medica) promoted "freedom, freedom, freedom of choice" with the corporate symbol of its seemingly ubiquitous butterfly. By enrolling in PHP, your options were plentiful: you could have access to nearly 4,000 participating providers, you could see a specialist without going through a primary care gatekeeper, and you could even see physicians outside the network and still get partial coverage.

However, freedom of choice wasn't free; you had to pay more for those choices. In 1990, PHP collected an average of $94 a month for each commercial enrollee, $12 more than the $82 collected by Group Health. (These numbers are taken from my analysis of HMO annual filings for Minnesota Managed Care Review.)

Why is choice important? Some purchasers insist on broad provider choice because, given the lack of comparative information on providers, it offers protection against being stuck with poor-quality physicians. Or maybe insisting on choice has less to do with notions of quality and more to do with keeping employees happy. Many employers buy choice plans to ease the transition to managed care and include most of the physicians that their employees were already seeing.

Clearly, freedom of choice has strong appeal. The product now called Medica Choice is probably the most popular health plan in the area with both employers and employees.

In fact, open access plans are so successful around the country that many classic HMOs have changed their approach. Instead of promoting themselves as low-cost plans, they have contracted with more physicians and tout themselves as the health plan for customers who value choice. In the Twin Cities, HealthPartners, Medica's major competitor, has a new offering called "Ultimate Choice" and advertises that it provides access to 7,000 physicians.

Competing on provider choice has become even more important because the price advantage that closed network HMOs enjoyed has eroded over the years. By 1995, the gap between HealthPartners and Medica had narrowed to $1.70 per member per month. (The comparison is not exact, since HealthPartners has expanded its provider network and because the Medica figures include its other commercial products with a more limited provider network.)

HealthPartners' Ultimate Choice builds on the competing care system model of Choice Plus, the health plan developed by the Buyers Health Care Action Group (BHCAG). Those employers wanted to hold providers more accountable by getting better information about cost and quality using a unit of analysis that was smaller than an HMO's entire network.

In both plans, enrollees choose from a list of care systems, which are subnetworks built around primary care physicians. Care systems may include their own specialists or may contract with specialty practice groups. Each care system is priced at one of three levels—low, medium, and high—and enrollees' contributions to the cost of coverage will increase if they choose a more expensive care system. Once they have selected a care system, enrollees must get their care from those providers to enjoy the full benefits of the plan. During the year, enrollees may switch to other care systems, but only to one at the same cost level or lower.

Will consumers view these plans as providing true freedom of choice and as viable competitors to Medica Choice, or will they see plans like Choice Plus and Ultimate Choice as limiting access to providers? One company left BHCAG over this issue, saying that the company and its employees were very happy with their provider choice plans and saw the new Choice Plus as actually limiting choice.

Choice takes different forms. Under Ultimate Choice, the HMO contracts with many physicians and practice groups, but enrollees must

select a primary care provider who regulates how they use the system. Some care systems permit self-referral to specialists, but only those within that care system. In many markets, HMOs have eased access to specialty physicians. They found that most referrals were routinely granted and that difficulty in securing a referral was one of the key sources of enrollee dissatisfaction.

While HealthPartners promotes the availability of 7,000 physicians through Ultimate Choice, the real choice is between 40 groups composed of about 2,200 primary care physicians in Minnesota and neighboring states. Some of the groups are large, though often heavily weighted with specialists. Others are small, like Camden Physicians in Minneapolis, with 21 doctors.

Is this promotion misleading to consumers? Colorado regulators are investigating HMOs that use a system of "physician pods" or personal care networks to restrict members to specific groups of doctors and hospitals based on their choice of primary care clinic. The HMOs promote the large number of doctors in their plans. However, enrollees cannot go to physicians outside these pods—even though the doctors participate in the HMO's full network—without changing primary care doctors.

Experimenting with new models can serve everyone's interests—consumer, employer, provider, and health plan. Consumers want access to a wide range of providers, and physicians want access to patients. Employers want to keep employees happy while holding down their costs, and health plans want to collect premiums that cover the actual cost of care plus a surplus. At this lunch counter, feel "free" to order anything on the menu—just be ready to pay more for steak than for hot dogs. MM



"HealthScene Minnesota" is an occasional column by Allan Baumgarten, J.D., a consultant on health care policy, finance, and local market strategies and the author of "Minnesota Managed Care Review" and "Colorado Managed Care Review," annual reports analyzing key trends in those health care markets.

Urgent Care

HealthPartners is an organization committed to preventive medicine, health promotion and high quality health care. We are seeking BC/BE Family Practice, and Internal Medicine and Pediatric physicians to work evenings and weekends at our Urgent Care clinics.

The Urgent Care clinics are supported by a 24-hour CareLine that is staffed with specially trained registered nurses. These nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic, which are located in Apple Valley, Brooklyn Center, Minneapolis, St. Paul and Woodbury. Physician staffing is based upon specific clinic needs and qualified physicians receive an excellent hourly salary and paid malpractice.

For more information on these positions, please call Laura Gaylard at (612) 883-5453 or send/fax your CV to HealthPartners, Physician Services, 8100 34th Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309, FAX: (612) 883-5395. You may also e-mail inquiries to: laura.j.gaylard@healthpartners.com. EO/AA Employer.

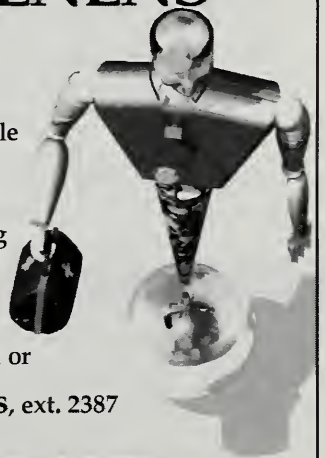
HealthPartners

HealthPartners' mission is to improve the health of our members and our community

Staff Care, Inc.

"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS



- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging

Ask for:

John Moberly, ext. 2381 or

Melanie McReynolds, ext. 2387

(800) 685-2272

http://www.locumsnet.com

Staff Care is proud to sponsor *the Country Doctor of the Year Award*

Unable to place J-1 or H-1 physicians

MMA's Chief Doctor

HARDLY A STRANGER TO CHANGE, MMA CEO PAUL SANDERS, M.D., SAYS HIS MAIN JOB IS TO HELP PHYSICIANS TAKE A LEADERSHIP ROLE IN MINNESOTA'S EVOLVING HEALTH CARE SYSTEM.

By Lorrie Holmgren



PHOTOGRAPH BY JOHN NOLTNER

Growing up as a minister's son, Dr. Paul S. Sanders learned to adapt to change. His family traveled from parish to parish, quickly making friends, but not staying anywhere long enough to put down roots.

Now, as chief executive officer of the Minnesota Medical Association, Sanders relies on the important lessons his nomadic childhood taught him. "I'm able to seize the opportunities change offers and, at the same time, appreciate stability and enduring values," he says.

The first physician to lead the MMA—and one of the first physician CEOs of a state medical association in the nation—Sanders took office in 1990, when Minnesota's health care system was undergoing revolutionary changes. HMOs were extending their influence, health system reform was underway, and physicians were beginning to look at their professional associations in a new light.

"I had no thought of becoming CEO until an outside consultant to the MMA's search committee encouraged me to apply," Sanders says. At that time, Sanders was practicing family medicine full time in Cambridge and serving as chair of the MMA Board of Trustees and vice chair of Midwest Medical Insurance Company. "Frankly, I was stretched too thin," he says.

Sanders chose to focus his attention on one job—leading the MMA staff as CEO. "Clearly, change was coming," he says. "Medicine was not going to continue as it had in the past. I believed I would have more opportunity to influence the future of medical practice by working with the MMA than with my patients."

Being a physician and longtime MMA member gives Sanders an advantage in his leadership role: he sees issues from a member's perspective. "When I represent physicians before the Legislature or regulatory boards, my M.D. gives me some enhanced credibility," he explains. "It also brings a challenge to prove my capability in nonmedical arenas, such as administration, finances, and staff management, which are not normally within the purview of physicians."

"If the MMA doesn't advocate for physicians on issues such as the 2 percent tax, nobody else will."

Sanders believes his most important mission as CEO is to help physicians take a leadership role in the changing health care system. At the same time, he is responsible for directing MMA action on day-to-day issues affecting physicians, such as seeking repeal of the 2 percent tax on health care revenues and the $400 surcharge on physicians' medical licenses, as well as managing the MMA's staff of 45.

As medicine becomes a big business and more physicians become health system employees, the MMA is under pressure to prove its continuing value. Since Sanders joined the MMA in 1971, he has seen physicians' attitudes toward membership in organized medicine change dramatically. "Back in the 1970s, 99 percent of physicians joined their medical association because it was what physicians did. Now, whether or not to join the MMA is a critical decision," he says.

Increasingly, physicians are turning to their specialty groups for medical education and turning to employers for representation. Sanders thinks this is a mistake. "Health plans represent the institution, not the physicians," he says. "If the MMA doesn't advocate for physicians on issues such as the 2 percent tax and take a critical look at plans that are decertifying physicians, nobody else will."

Sanders doesn't remember a time when he didn't want to be a physician. As a boy growing up in Iowa, he set up his own medical office on the back porch. His two most prized possessions were the *American Red Cross First Aid Manual* and the *Merck Manual of Medicine.*

When he was 10 years old, he thrust his right arm through a storm door, leaving a gash from hand to elbow. "My father took me to the doctor's office," he recalls. "I clearly remember the smell of alcohol and ether. I watched the doctor stitch my arm and thought, 'How fascinating! How could anyone want to be anything other than a physician?'

"It wasn't until I began practicing medicine that I realized the kindly old doctor—who didn't charge anything because I was the minister's son—had sewed my median nerve to my tendon," Sanders says.

Sanders majored in English and zoology at De Pauw University in Indiana, graduated from the University of Minnesota Medical School in 1970, and completed his training at the Sioux Valley Hospital in South Dakota in 1971. ⇨

In 1974, Sanders became the eighth physician to buy a business partnership in a privately owned multispecialty group in Cambridge. "Now it's a totally different environment," Sanders says. The group has 35 physicians. Allina bought the practice, which then merged with a hospital to become the Cambridge Medical Center, with clinics in Cambridge, Braham, and Soderville.

"The physicians are now employees, no longer owners of the practice—a shift that reflects the changes that are going on throughout the state." says Sanders, who still practices at the Cambridge Clinic one day per week.

Sanders says he sometimes misses the one-on-one relationships he had with patients when he practiced full time, but there are other aspects of modern medical practice he's happy to avoid. "Even though I delivered close to 1,000 babies, I don't miss getting up in the night, and I don't regret not being part of the bureaucracy," he says. "Increasingly, medicine as big business has lost the personal touches that made the doctor-patient relationship unique."

Sanders' partners in the Cambridge Clinic encouraged his participation in organized medicine. From 1980 to 1983 he chaired the Professional Liability Committee of the Minnesota Academy of Family Physicians (MAFP), served on the MMA Task Force on Professional Liability, and chaired the MMA Task Force on Risk Management. In 1981, he joined the Midwest Medical Insurance Company Risk Management Committee and served as chair from 1989 to 1995. He was elected president of MAFP in 1984 and chair of the MMA Board of Trustees in 1988. Sanders was board chair until 1990, when he became CEO.

Shortly before that, Sanders completed a mini-MBA in health care management at what was then the College of St. Thomas and completed a Bush fellowship focusing on quality assurance, professional liability and risk management, and administration—studies that helped prepare him for his new role as CEO.

Along with his wife, Gretchen, and his three children, Sanders has put down roots in Cambridge. The 42-mile commute to the MMA's Minneapolis office gives Sanders time to reflect on the challenges of the job.

One challenge is convincing physicians the MMA represents them, not just a small cadre of insiders. Sanders is particularly troubled when he hears physicians refer to "you guys over at the medical association." "It's not 'you,' it's 'us,' " he insists. "This association doesn't belong to the staff or to the officers. It's an association for *all* Minnesota physicians.

"When I go before the Legislature or the Board of Medical Practice," Sanders says, "I'm not just representing the physicians who pay their dues, but all Minnesota physicians. Physicians who don't join the MMA are letting others pay the freight. When the MMA pursues legislation to reduce the 2 percent tax and to prevent teenagers from buying tobacco, or promotes its 'Stop the Violence' campaign, we don't do it only in the name of physicians who are members.

"We have to do a better job of letting physicians know all that the MMA does for them," Sanders continues. "If we fail, we will lose members. It is our intention not to fail." MM

Lorrie Holmgren is editor of The Monitor, *the Minnesota Medical Association's newsletter.*



SPECIALIZE IN AIR FORCE MEDICINE.

ER Physicians. Radiologists. OB/GYNs and other specialists! Today's Air Force gives you the freedom to specialize without the financial overhead of running a private practice. Talk to an Air Force medical program manager about the tremendous benefits of becoming an Air Force medical officer:

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay each year

Examine your future in the Air Force. Learn if you qualify. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

Introspection in the

By Howard Bell

Organized medicine is taking a good, hard look at how it meets physicians' diverse and ever-changing needs.

The patient is aging gracefully and feeling good, with no serious complaints, except, perhaps, some unease about keeping up with the fast-changing world. In fact, the results of the workup are far better than the doctors expected. The patient is well, vital, and in surprisingly good shape.

Using a diagnostic flurry of surveys, organizational audits, focus groups, and think sessions, the patient—the Minnesota Medical Association—has performed a complete history & physical on itself and found that, unlike much of organized medicine, it is doing quite well.

"Organized medicine is still strong," says Raymond Christensen, M.D., MMA president and Moose Lake family physician. "And it is willing to embrace change to better serve physicians and remain the voice of medicine."

To maintain its vigor, the MMA has written a prescription for change: Work more closely with managed care organizations and specialty societies. Retool educational offerings to make them relevant to employed physicians, younger physicians, and female and minority physicians. Keep fighting for ethical patient care.

The MMA boasts an impressive two-thirds membership rate, among the highest for state medical associations nationwide. For the past 10 years, an average of 100 physicians have joined each year.

Other state medical societies haven't fared so well. Almost half count fewer than 50 percent of their physicians as members. California is one of the lowest, at about 34 percent. Even the American Medical Association, which is conducting its own evaluation of organized medicine—its much publicized Federation Study—counts only 41 percent of U.S. physicians as members.

"The MMA has done relatively well providing value to physicians," says MMA Chief Executive Officer Paul Sanders, M.D. "But we are concerned about the future."

That concern is based on the fact that physicians don't do business like they used to, so organized medicine can't either if it expects physician support. For one thing, medicine no longer presents a unified picture, making it impossible for medical societies to speak for all physicians all the time.

"There is no typical MMA member," according to a summary of the Minnesota Medical Association's 1996 physician survey (see related article, page 19). "There are substantial differences in the perceptions and needs of older and younger members, between males and females, between members in independent practice and those in managed care."

The Roof Covers Employed Docs, Too

"One of our biggest challenges is to find ways to represent employed managed care physicians and avoid the perception that we are somehow anti-managed care," Sanders says.

Managed care and integrated health systems are old stuff in Minnesota. Both shape virtually every type of practice, whether physicians are independent or employed. Half of Ramsey Medical Society's members, for example, are employed by large systems. A third of the MMA's membership belongs to group practices of more than 100 physicians.

The MMA is tightening relationships with managed care organizations (MCOs) and specialty societies by reorganizing committee structures and nurturing close ties with groups like the Minnesota Medical Group Management Association. They hope to preserve a uni-

House of Medicine



ILLUSTRATION BY ANDREW POWELL

fied House of Medicine, not necessarily a house always in agreement, but one that can rally around policy and legislative issues affecting all Minnesota physicians.

"Historically," says Sanders, "we were perceived as not very friendly toward managed care, but we're erasing that perception and bridging the gap. Our message to MCOs is that we are an inclusive organization marked by diversity. Join us and help us change the fabric of medicine."

Among some larger health systems, MMA membership is low, Sanders acknowledges. "We struggle with employed physicians who perceive that what we do overlaps with what their employer provides them."

Perception is the operative word here, according to Byron Crouse, M.D., director of University of Minnesota–Duluth's Department of Family Medicine and immediate past president of the Lake Superior Medical Society. "Everyone thinks their system will speak for them," Crouse says. "Whether that's true is questionable. Systems have business concerns, and doctors have patient care concerns. The two often conflict."

"Do systems represent docs or the system the docs work for?" asks Roger Johnson, CEO of the Ramsey Medical Society. Johnson believes physicians employed by large groups sometimes feel insulated from the political and economic forces shaping medicine. "They feel their employer can handle all their needs," he says.

Although no Minnesota health system openly discourages physician involvement in organized medicine, say medical society execs, they do differ in how positive their leadership is toward organized medicine.

The Mayo Clinic, St. Mary's/Duluth Clinic, and Park Nicollet Clinic, for example, pay the full tab for their physicians' MMA dues, which automatically include county society dues. Most larger employers, like Allina and HealthPartners, offer a lump sum from which physicians pay for MMA and specialty society membership, continuing medical education, and journal subscrip-

House Organs in Tune with Modern Medical Practice

As organized medicine has adjusted to changes in society and health care, its voice has had to change. State medical societies speak to their members through publications that must adapt to an evolving audience.

State medical associations have had multiple incarnations. Postrevolutionary local societies were invested by legislatures with professional licensing power. After a coalition of state societies established the AMA in 1848, a rush of new state societies blossomed. Many, like South Carolina's, called for suppressing quackery, promoting professional ethical standards, and enhancing medical teaching. Between 1900 and 1910, the AMA's internal reorganization and expanded cooperation with state societies galvanized organized state medicine into wider political activities, which continued to broaden throughout the century. Malpractice, hospital staff privileges, CME, and hospital insurance were added to state society plates in the 1920s and '30s. During their first 50 years, medical societies published mostly transactions of meetings and conferences.

As medical practice expanded geographically and scientifically in the 1890s, society journals sprouted. The precursors to *Minnesota Medicine,* first published in 1917, were the transactions of the Minnesota State Medical Society, founded in 1869, followed in 1899 by the *St. Paul Medical Journal.* Scientific articles dominated *Minnesota Medicine* and all state medical journals until the mid-70s, when social and health care evolution changed to revolution. In 1976, acknowledging that physicians looked to their specialty publications for clinical information and sensing the impending managed care tremors, *Michigan Medicine* became the first of many state journals to redirect its focus to political and socioeconomic issues.

Minnesota Medicine made a similar switch in 1988. Today's panorama of state medical society publications displays diversity. Although clinical articles still dominate some state medical journals, like Delaware's, most societies have limited their scientific contents to locally generated papers or abstract-like "shorts." A paragon of peer-reviewed clinical articles since 1902, the *Western Journal of Medicine* was jettisoned as the official journal of nine western state medical associations when the California Medical Association (CMA) sold it to Carden Jennings Publishing Company in 1996. The CMA continues to publish *California Physician,* a maga-

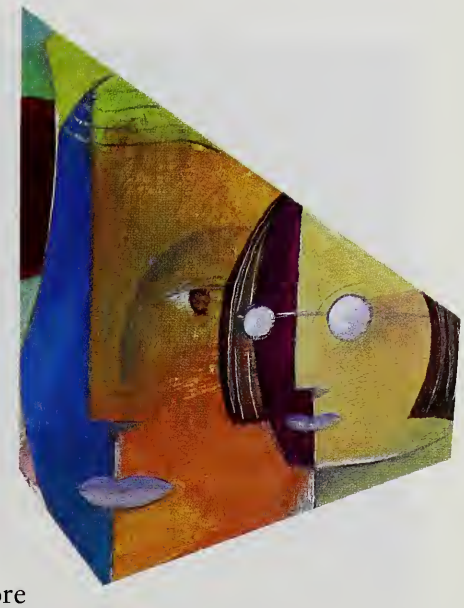
tions. MMA, AMA, and county society dues total up to about $1,100. Physicians allocated less than that may decide to spend the money on their specialty society dues and CMEs.

"We cannot rely on systems to pay their doctors' membership dues," says Judith Shank, M.D., a dermatologist with Metropolitan Dermatology in Plymouth and chair of MMA's Strategic Planning Committee. "We realize we must provide enough value to physicians that they will participate on their own."

Support of organized medicine is a matter of physician responsibility, Johnson says. "Physicians have to say to themselves, 'I'm a professional and I'm going to support my professional organizations.' "

A New Generation: No More Committees, Please

Organized medicine is struggling to attract younger physicians, especially women, who have different priorities and obligations than their older colleagues, according to Sanders. "Younger physicians tend not to be joiners," he says. Many are not as married to the profession, because of outside interests and family obligations.



The challenge is determining how to involve younger physicians who want more free time, not more committee time. "They don't want to add meetings to an already stressful obstacle course of preauthorization hoops and reimbursement paperwork," Crouse says.

Women now comprise 24 percent of Minnesota physicians. More than half of medical school graduates will soon be women. Organized medicine at all levels is reshaping educational and support services to better serve them.

Women physicians want clinical CMEs, but they also want help with time management, parenting issues, and collegial support for their stressful lifestyles, according to the 1996 MMA survey of members and nonmembers.

"Most women physicians are young," Shank says. "They're raising kids and have neither the time nor the energy to actively participate on organized medicine committees. Women have not been excluded from the MMA, they've opted out. That's going to change as they get older and have fewer family responsibilities."

In fact, more women are expressing interest in the MMA, according to Shank. "I tell them the MMA offers enormous opportunities for women and is very anxious to have them participate."

The MMA's Committee on Women Physicians is trying to involve more women, but it's not easy, says committee chair Anne Towey, M.D., a Park Nicollet ophthalmologist. "Women say they don't have time to leave their hospital or clinic to attend meetings. We're testing an effort at three hospitals to bring programming of interest to their workplace."

Shank describes participation in organized medicine as a learning curve. "I had no interest in organized medicine when I got out of school. I got interested once I saw what was going on politically and what organized medicine can do to protect the profession and

zine with articles on medical politics and economics, practice issues, and CMA activities. Minnesota and Iowa follow this style, as does *Texas Medicine,* but with glitzier graphics.

Some medical society publications seem to have been hit by *USA Today*. Seeing a physician audience with too little time and too many words to inhale, Ohio, Illinois, and New York publish tabloid-style newsletters in lieu of magazines. Short articles, eye-catching graphics, and lots of pictures provide word bites and visual images for harried readers. Economic reality has also hit. The Virginia Medical Society, among others, has cut back its publication from monthly to quarterly. Some journals, like *Indiana Medicine* and *Nebraska Medicine*, have died. (Boasting an 83 percent satisfaction rate among recently surveyed MMA members, *Minnesota Medicine* appears to be doing quite well.)

Every organization needs a voice to inform, edify, entertain, and coax its members. The voice of state medical societies has changed over the past century and will in the next. But state medical journals will speak on.

—Charles R. Meyer, M.D.
Editor-in-Chief



advance an individual's career."

'Special' Interests

Serving as a political and legislative advocate for the profession is MMA's most important mission, according to the association's survey, conducted by an outside consulting firm. But it's getting harder for the MMA to represent all physicians all the time as each specialty competes for its share of referrals and reimbursements.

"We are very concerned," says Christensen, "that as dollars available for membership dues decrease, physicians will give priority to specialty societies."

Sometimes physicians must turn to their specialty societies for legislative support, says Joanne Reed, M.D., president of Minnesota's Academy of Ophthalmology (MAO). "The MMA tends not to take a stand on issues that create division between specialties."

Take the Health Care Financing Administration's plan to slash reimbursement for surgical procedures under RBRVS while modestly increasing reimbursement for some primary care procedures. The academy worked with other specialty societies at the state and national level instead of with the MMA, which, Sanders says, worked through its members in the AMA House of Delegates to achieve equitable reimbursement rates for all specialties.

Reed says MAO now spends more time on economic and legislative issues instead of always relying on the MMA to represent its interests. "We work hard to educate third-party payers about what is necessary to provide good ophthalmology care to patients."

The ophthalmologists, like other specialty groups, work closely with the MMA on issues that affect physicians in general, such as scope of practice distinctions between physicians and nonphysicians. When chiropractors wanted to perform Department of Transportation physicals on truck drivers, the ophthalmologists joined a united front with the MMA and other societies to defeat the initiative, even though it didn't directly affect ophthalmologists.

"It's important to remember that we are physicians first, specialists second," Reed says.

The Minnesota Academy of Family Physicians (MAFP) also is doing more of its own policy and legislative work, according to the group's president, Kenneth Kephart, M.D. "We're starting to involve ourselves more in worksite issues, such as the number of hours we work, quality issues, and professional burnout. We won't become a union, but we will function in some ways like a union."

MAFP has met with health plans to discuss proposed reimbursement reductions for physician assistants and nurse practitioners who work under physician supervision. They're also discussing family practitioner reimbursement for primary mental health services.

Speaking with One Voice

Physician credibility takes a hit when specialty societies swarm the Legislature with specific requests that benefit particular interests. "We need to meet and compromise, which the MMA can help us do," Kephart says.

Efforts by ob/gyns to gain primary care status and direct patient referrals illustrate a point about credibility and speaking as one voice through the MMA. If the ob/gyn society lobbies for direct patient access, it's perceived as a turf issue. If the MMA endorses it, it's perceived as a quality of care issue.

"We would hope that specialty groups would not take their concerns to the Legislature," Christensen says. "We would hope we can resolve our differences within the House of Medicine."

Specialties have a right to fight for their own interests, but not at the expense of the profession, Crouse says. "We don't always agree on things, but sometimes we must reach common ground and speak as one voice. Letting politicians solve our problems allows the Legislature to practice medicine by proxy."

One reason organized medicine has had difficulty uniting physicians, according to Sanders, is because its various groups sometimes, and mistakenly, think the MMA is biased against them. "Rural docs think we're an urban association," he says. "Urban groups think we're an out-state organization. Large groups think we favor small groups, small think we favor large. It's the same with primary care vs. other specialties. If you look at our membership and our record, you see we don't give special treatment to anyone."

As an umbrella organization, the MMA can't afford to give special treatment to any one group. Instead, it has

proven effective in defending the entire profession against many political and marketplace challenges. "The MMA's role was crucial in preserving due process with the Board of Medical Practice and preventing overzealous investigations," says Tim Crimmins, M.D., MMA board chair.

Offering another example, Crimmins points out that the MMA helped steer the Minnesota Health Data Institute away from publishing mortality data for individual physicians and toward comparing insurance policy and care system data. "A lot of people don't realize what we do and how important it is to the profession," Crimmins says.

Organized medicine is determined to preserve itself so it can preserve the profession. "You don't get reimbursed for fighting the battle for organized medicine," says Christensen, "but we have an obligation to fight for our profession."

Johnson concurs: "If physicians as a group do not advocate for themselves in the public, media, and Legislature, others will determine what ethics and laws physicians must live by."

Christensen argues that practicing medicine has two parts: the clinical and scientific aspects and the policy and legislative side. "We have a responsibility to advocate for our patients, which we must do free of corporate control," he says. "Policies and legislation affect patient care. If we shirk our responsibility in that arena, we shirk our responsibility as physicians."

Legislation and policy matters are what organized medicine does best and what physicians expect it to keep doing. Time will tell if the MMA's prescription for change keeps organized medicine vital rather than obsolete.

"Am I fighting for a dinosaur?" asks Christensen. "I don't think so." MM

Howard Bell is a free-lance writer living in Onalaska, Wisconsin.

PHYSICIAN ADVISORS

Managed Care, done well, can be a powerful and effective agent for improving the state of our nation's health care system. And to ambitious M.D.s, managed care offers a rewarding opportunity to gain new skills in one of today's fastest growing and most profitable medical arenas.

We are United HealthCare, an expansion-driven national leader in the managed health care arena. And right now we have opportunities for physicians in Minnesota to join us and become involved in reviewing cases. We are looking for clinical experience in primary care specialties such as Internal Medicine and Family Practice.

We're excited about our company's future in the dynamic managed care industry—and the significant contribution we're making towards a better health care system. Join us. For consideration, please send your resume and CV to: A. Rasmussen, United HealthCare, Rt. MN12-S286, P.O. Box 1459, Mpls., MN 55440. Fax (612) 992-5236. We promote a drug-free environment and are committed to diversity in the workplace. EOE M/F/D/V

Geriatrician

Extended Care Program
Department of Medicine
Hennepin County Medical Center
Minneapolis, Minnesota

Hennepin County Medical Center, a major teaching affiliate of the University of Minnesota, is seeking additional internal medicine-geriatric medicine faculty for its Geriatrics and Extended Care division. The new faculty member will focus his/her clinical activities in the long term care and ambulatory setting and participate in teaching medical residents and students on Geriatrics rotation. Protected time for scholarly pursuit is available for qualified physicians in this academic medical setting.

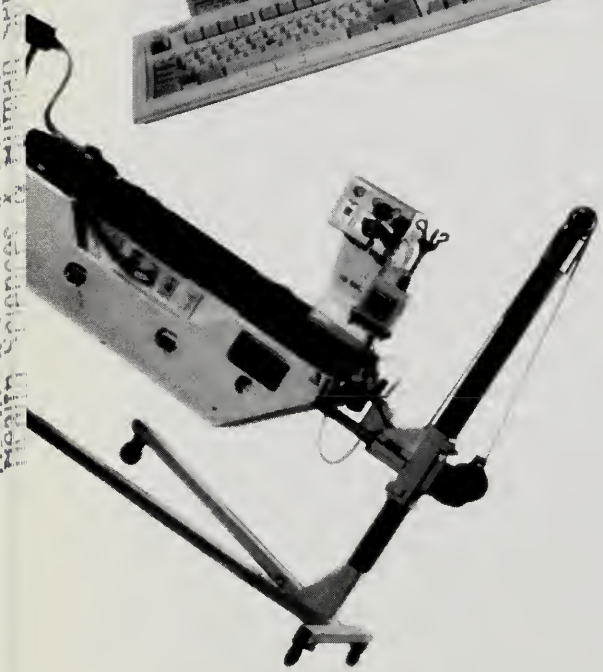
Full time, renewable term university academic appointment is available based on experience and qualifications.

The Hennepin County Medical Center, Hennepin Faculty Associates, and University of Minnesota are equal opportunity educators and employers, who specifically invite and encourage applications from women and minorities.

Submit application to:
Lawrence Kerzner, M.D.
Chief, Geriatrics Division
Director, Extended Care Division
Department of Medicine
Hennepin County Medical Center
701 Park Avenue
Minneapolis, MN 55415

EQUIPMENT LEASING *MADE easy*







Whether you need the latest in diagnostic equipment for your exam room or a new computer for the business office, MMBR Equipment Leasing offers health professionals a truly versatile, service-oriented leasing program. *One-stop shopping.* MMBR Equipment Leasing provides a single location for the leasing funds you need, with 15 different funding sources. This ensures you're getting the best rates available. *Easy processing.* You can access to up to $125,000 from a one-page application, and get approval within 24 hours. With MMBR Equipment Leasing it's as simple as a phone call. *Plans specially developed for you.* Customized lease plans are available that provide $2,000 to $2,000,000+ at terms that fit your needs. Ask about our lease options that require no personal guarantee. *Just another equipment leasing company? Not even close.* Whatever you need for your lab or office, whether you're in a start-up or established practice, MMBR Equipment Leasing makes getting it easy. For personal attention and unparalleled service, call 623-2860, or toll free 800-298-MMBR (6627).

MMBR

EQUIPMENT LEASING

MINNESOTA MEDICAL BUSINESS RESOURCES

OWNED BY MMA & HMS

Physicians Give MMA High Ratings

MMA members are highly satisfied with the association, but that doesn't mean MMA leaders are feeling self-satisfied.

Stephen Dombrosk

Minnesota has long been a leader in quality health care. One source of our success may be the high level of collegiality and professionalism among Minnesota physicians. This commitment to the profession is demonstrated by physician support of the Minnesota Medical Association; more than two-thirds of the state's physicians belong to the MMA. In fact, the MMA, its component medical societies, and state chapters of specialty societies are the glue that maintains the cohesiveness of the physician community, especially during these times of rapid change.

How has the MMA met the needs of its members and what must it do to continue to serve members in the future? To answer these questions, the MMA commissioned a survey of Minnesota physicians in the fall of 1996. The results were overwhelmingly positive, and heartening. Still, the MMA plans to keep making improvements to meet the diverse needs of physicians practicing in today's shifting medical marketplace.

The Survey

The goal of the survey was to determine how the MMA could more effectively meet physician expectations and enhance its ability to recruit and retain members. These two dimensions are inextricably linked. The strength of any association is largely determined by the support it receives from its members, and the support members give an association is strongly affected by the association's perceived effectiveness.

The professional research firm of Anderson Niebuhr & Associates conducted the survey. Both MMA members and nonmembers were asked about their attitudes toward participation in professional medical organizations. The high response rates—79 percent for members and 65 percent for nonmembers—were crucial to ensuring the validity of the results.

The Results

The results covered three areas: member satisfaction, priorities, and differences between members and nonmembers.

Member satisfaction

Overall, MMA members report high levels of satisfaction with the association. Eighty-one percent describe themselves as being satisfied or very satisfied; just 6 percent say they are dissatisfied.

The table (page 20) lists MMA's 10 service areas. Those receiving over 50 percent satisfaction scores include this journal, *Minnesota Medicine*; the MMA Directory; information received from MMA on political issues affecting physicians; public health campaigns; legislative advocacy; and the two-page publication *Monitor in Brief*. Three services received many "don't know or haven't used" responses: networking opportunities, trustee representation, and staff responsiveness.

MMA priorities

The survey confirmed two MMA priorities—advocacy and public health campaigns. Both members and nonmembers agreed that the MMA's most important function is to serve as a political and legislative advocate for the profession. Among members, 39 percent said advocacy is an essential service, with another 41 percent identifying it as *very* important. When asked who should provide this service (the MMA or a specialty, component, or clinical organization), a resounding 84 percent replied that this activity belongs to the MMA. Nonmembers also cited advocacy as the top reason for joining a professional medical association. Seventy-two percent of nonmembers agreed that this is a role of the MMA.

Also rated near the top were MMA public health campaigns, an area in which the MMA has played a role in setting the national agenda. The "Stop the Violence" campaign has won national and state awards and has provided the model for a similar national campaign by the AMA. The long-standing efforts of the MMA in battling tobacco use also are well-known and emulated.

Twenty-one percent of members view these activities as essential, with another 43 percent identifying them as *very* important. Only 4 percent of members responding did *not* see this as an important function of the association. Nonmembers agree; 41 percent consider the visibil-

Table

Physician satisfaction with MMA's 10 service areas

Service	Satisfied	Dissatisfied	Don't Know/ Haven't Used
Minnesota Medicine journal	83%	6%	11%
MMA Directory of members	77%	1%	22%
Information on political issues affecting physicians	76%	3%	21%
Public health campaigns	70%	5%	25%
Legislative advocacy on behalf of physicians	68%	11%	21%
Monitor in Brief	67%	2%	31%
Educational programs offered by MMA	48%	4%	48%
MMA staff responsiveness	43%	5%	52%
MMA trustee representation in your region	36%	7%	57%
Networking opportunities with other physicians	35%	3%	62%

ity of the organization in supporting public health campaigns as an essential or very important reason for joining a professional medical association.

When asked who should provide this service, both members and nonmembers identified a division of responsibility between MMA and AMA. Members felt that the MMA plays a slightly more important role than the AMA in this area, while nonmembers felt 3:1 that public health is an AMA function. Clearly, the MMA must educate nonmembers about its success in developing initiatives that are later adopted nationally.

Differences between members and nonmembers

Of course, there is one critical area in which nonmembers and members disagree—whether or not to belong to the MMA. While there is broad agreement that the MMA serves a vital role in the political arena, some physicians choose to support these efforts, while others do not. Complicating matters, Minnesota physicians receive the benefits of MMA lobbying and advocacy whether or not they join the association. MMA work in public health also benefits all physicians and Minnesota residents.

The challenge the MMA faces is to persuade nonmembers to come aboard. In many ways, the challenge resembles that of public broadcasting, which needs to persuade listeners and viewers to support activities they can receive without making a contribution. Fortunately, many nonmember physicians are open to the idea of membership. Eleven percent said they are very likely to join the MMA, and another 24 percent indicated they are somewhat likely to join. Only 7 percent of nonmembers said they will never join.

Current members play a critical role in helping to win nonmember support. Twenty-four percent of nonmembers state that the influence of their colleagues who are MMA members is an essential or very important reason for joining; 50 percent cite this as an important reason.

The cost of membership dues is an important consideration for nonmembers and members alike. The MMA has been able to hold dues rates constant for the last three years, despite inflation and demands for expanded activities. Yet the single most important method to hold the line on dues rates is to retain and expand the pool of Minnesota physicians who support the efforts of the association through membership. In other words, the more members, the more equitable sharing of the cost among the physician community.

Looking Ahead

The MMA Committee on Strategic Planning, chaired by Judith Shank, M.D., is reviewing the survey results. This committee will be exploring ways in which the association can build on the positive messages contained in these results, while addressing additional needs the survey revealed. Your comments on this survey can be sent to Dr. Shank and the committee at the MMA offices, or via e-mail to: sp@mnmed.org. MM

Stephen Dombrosk is the MMA's director of Membership and Information Systems.

Partners In Your Future



"I would say the number one reason that we stay with MMIC is that they provide us with peace of mind. We know we're going to be well protected and vigorously defended if there is a lawsuit."

Peter Bartling
Executive Director
Consulting Radiologists Ltd
Minneapolis, MN

In today's changing medical environment, physicians need to view their professional liability insurer as an important partner in their future. And what better partner can a physician have than a physician-owned and controlled liability insurer such as Midwest Medical Insurance Company. A company that understands a physician's desire to practice the art of medicine.

As your partner, MMIC is here to assist you in your new working relationships and to develop products and programs which improve patient care and lower liability exposures.

MMIC is here for the long term. We bring to the partnership a financial strength of over $251 million in assets and a total equity of over $104 million. Our rating from A.M. Best is A (EXCELLENT).

For a competitive quotation and other information on services offered by MMIC, please call us at 1-800-328-5532.

MMIC

MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S. Minneapolis, MN 55435-1891

100 YEARS

Gillette Children's Specialty Healthcare

FOR KIDS' SAKE



PHOTOGRAPH COURTESY OF GILLETTE CHILDREN'S SPECIALTY HEALTH CARE

For a century, Gillette has stayed true to its mission: helping children with long-term disabilities and their families gain greater independence and enjoyment in life.

For several weeks last October, Gillette Children's Specialty Healthcare was caught in a media frenzy that most hospital administrators would envy. Three of their physicians published an article in the medical journal *Pediatrics* about brain injuries in children who were pinned underneath automatic garage doors. Gillette physicians have published hundreds of journal articles over the years, and occasionally received media attention for them. But this particular article sparked widespread interest as editors across the country recognized a story that would resonate with their readers.

STORY BY JEREMIAH CHRISTOPHER WHITTEN

From the time the garage door study began two years ago, to its publication last fall, more than 100 calls reached Gillette's public relations department. By the time the news cycle of this story played out, Gillette Children's was covered by the *New York Times*, ABC News, and by dozens of newspapers, television and radio stations, and cable networks around the country.

Yet, for all of Gillette Children's acclaim, many people in its hometown haven't the faintest idea that it exists.

"It's strange," says Gillette Medical Director James Gage, M.D. "We're known internationally, and yet there are people in St. Paul who have never heard of us."

The relative anonymity of Gillette Children's may be due to its narrow focus on children with long-term disabilities, such as cerebral palsy, epilepsy, spina bifida, and brain and spinal cord injuries. In addition to providing rehabilitative services, Gillette offers counseling to children and family members.

Margaret Perryman, Gillette's seventh president, says being an advocate is almost as important as being a caregiver. "We need to help society incorporate greater numbers of people who are disabled into the fabric of the community," she says. "We need to start asking 8-year-old kids in wheelchairs what they're going to be when they grow up, which is a question they don't get asked very often. And we need to start telling people that this child is going to get a job someday, so we need to see what we can do to facilitate that."

Like all hospitals, Gillette Children's has a mission statement. It is three paragraphs long and contains standard language about quality and expertise. But it also includes a goal so broad and undefined as to defy simple explanation: "to help children and their families realize greater independence and enjoyment in life." To someone reading that statement in 1997, it may sound like the politically correct musings of a "new-age" liberal. But it is the same goal of the people who established Gillette Children's 100 years ago.

In 1896, a young, disabled Carleton College student named Jessie Haskins presented a paper before the Minnesota Board of Corrections and Charities entitled "The Need for an Institution for Crippled and Deformed Children." The following year, Arthur Gillette, M.D., presented a paper to the same board entitled "The Duty of the State to Its Indigent Crippled Children." Gillette assured legislators that providing specialized treatment to children could be accomplished "at a fraction of the cost of lifelong maintenance as disabled adults."

That same year, in 1897, the Legislature appropriated $10,000 to establish the first publicly funded hospital for children with disabilities in the United States.

The site was the City and County Hospital in St. Paul, where a ward was set aside for the new facility. The hospital was staffed by Gillette and by volunteers from the University of Minnesota Medical School. Legislators were impressed that the doctors offered their services free of charge. (Gillette physicians continued to serve without pay until 1937, when the Legislature approved a small monthly stipend.)

It didn't take long for the hospital to outgrow its first home. In 1907, the state purchased 23 acres near Lake Phalen to construct a new campus. The first building opened in 1910, and soon the hospital had about 50 young patients. Lake Phalen was a large facility with an open ward that housed dozens of children in one large room. There was no privacy and few com-



PHOTOGRAPH COURTESY OF ST. PAUL PIONEER PRESS

Photos: Page 22: Jean Conklin, hospital superintendent at Gillette for 31 years, with some young patients in the late 1970s. The portrait is of Arthur Gillette, M.D., who founded Gillette Children's Hospital in 1897.

Page 23: Two boys in a large, open ward at Gillette's Lake Phalen campus (circa 1950).

forts, but life at the hospital was an improvement for most of these children who were from poor families.

The average length of stay for a child at the turn of the century was over 400 days (today it is six days, with most children seen as outpatients). If children were going to be hospitalized that long, administrators realized they would have to educate them. A kindergarten program began in 1898. In 1900, the hospital started a formal education system that developed into a full secondary school program. High school diplomas were awarded in ceremonies on hospital grounds. (In later years, Gov. Harold Stassen frequently presided over the ceremonies and handed out diplomas.)

Despite its humble origins, Gillette took a leading role in orthopedic surgery. Robert Winter, M.D., who spent 35 years on Gillette's medical staff and recently retired from active practice, remembers a day in 1960 when, as a young resident, he participated in the first scoliosis surgery in the Midwest using a steel rod. The "Harrington Rod" was invented by a physician from Houston who visited Lake Phalen to teach Gillette physicians how to use it. Winter assisted in the first operation, and physicians from Los Angeles, Milwaukee, and the Mayo Clinic traveled to Gillette to observe.

"I remember thinking, here's this tiny hospital in a park on the edge of town, and there's all this cutting-edge work going on. I never forgot that day," says Winter.

Medical care at Lake Phalen was of the highest caliber, but it was limited. The small, devoted staff couldn't provide 24-hour services. Physicians recall having to send patients to downtown St. Paul by ambulance for a simple x-ray if it was needed after their own technician went home for the night.

Lake Phalen was also a victim of its own success. As polio and tuberculosis were virtually eliminated, Gillette's inpatient population declined. The hospital was evolving into a clinic-based outpatient facility. Yet the Lake Phalen campus was built to serve an inpatient population. The beautiful campus by the lake, much loved by the patients and staff, was becoming obsolete.

"Lake Phalen was like an English country hospital," says Gage. "It had lots of open air and the charm of an old hospital, but you can't run a hospital on charm. They needed to run a high-intensity children's hospital."

Rather than build a new facility, Gillette wanted to purchase space and contract services from an existing health care facility while maintaining its own independence. Offers were considered from Hennepin County Medical Center, St. Paul-Ramsey Medical Center, Fairview Riverside, the University of Minnesota, and St. Paul Children's. Gillette finally accepted an offer from St. Paul-Ramsey, where they moved in 1977. Gillette owns the fourth floor of Ramsey, where it now receives up to 1,000 inpatient and 30,000 outpatient visits each year.

Affiliation with a Level I trauma center gave Gillette physicians access to the intensive medical services they needed. Gillette maintains its own staff and board of directors but purchases services such as x-rays, CAT scans, MRIs, and laboratory services from Ramsey on a fee-for-service basis.



PHOTOGRAPH COURTESY OF *ST. PAUL PIONEER PRESS*

Recreation has always been an important part of care at Gillette. When the hospital was located at Lake Phalen, fishing was close by and a common form of physical therapy (circa 1950).

Shortly before the move, Gillette ended its dependence on the state Legislature and became a self-supporting nonprofit corporation. Individuals and third-party payers began to pay for medical services.

Gillette grew again in 1987, when it constructed the nation's second fully equipped Motion Analysis Laboratory. The "gait lab" allows physicians to evaluate the neuromuscular problems of children who have difficulty walking. Sensors are attached to a child to monitor muscular activity. Reflective balls are taped to the child's legs to measure movement and rotation. Five cameras take pictures of these reflectors 30 or 60 times per second. A computer then creates a three-dimensional image of the child's walking cycle, providing an invaluable diagnostic tool.

True to the spirit of its early volunteer medical staff, Gillette's physicians contributed over $300,000 of their own money to build the $700,000 lab.

Robert Kriel, M.D., a pediatric neurologist at Gillette for 26 years (also the lead author of the garage door study in *Pediatrics*) says that despite all of the changes over the years, one thing has remained constant: Gillette has always attracted a loyal and devoted staff of physicians and employees.

"The people at Gillette, almost to a person, are wonderful to work with," he says. "I don't know how it came about, because, obviously, they were hired by different people over many years, but somehow it perpetuated itself. A lot of things just fell into place to make this a wonderful hospital to provide medical services, have professional growth, and perform research."

Gillette has also stayed true to its mission. Using logic that sounds remarkably similar to Dr. Gillette's own words 100 years earlier, hospital President Margaret Perryman speaks forcefully about the necessity of caring for children with disabilities.

"One of the greatest risks that we face is the shortsighted view that investment in children with disabilities costs too much. We have to help policymakers understand that *not* investing in children with disabilities costs too much."

Steven Koop, M.D., an orthopedic surgeon at Gillette who is writing a history of the hospital, says that Minnesota sets a standard for the rest of the country. "Minnesota has always strongly supported children with disabilities," Koop says. "Minnesota is a national leader, and as Gillette begins its second century, we certainly hope that will continue." MM

GILLETTE'S FIRST PATIENT

Royal Gray, a 10-year-old boy from Pine City, was admitted as Gillette's first patient on October 27, 1897. The boy had Pott's disease, a common illness among children who drank milk from cows infected with tuberculosis. In a report to the University of Minnesota Board of Regents the following year, Arthur Gillette, M.D., described the results of his treatment:

"Our first patient was a little boy from a country district. His parents had spent what little money they could get together from time to time for treatment and apparatus, but the treatment was so interrupted owing to the lack of funds that the few dollars they spent in this direction were wasted and he came to us unable to walk—almost bent double by the deformity of the back and contraction of the muscles. He had seven discharging sinuses. Today, without causing him one bit of pain or suffering, all of these sinuses are healed, he is almost perfectly straight and running about the campus with bat and ball, a pleasure he has never known before."

Royal Gray grew up to become a rural mail carrier and the owner of a taxi business. He married, had two children, and enjoyed a healthy life.

An official history of Gillette Children's Specialty Healthcare will be published this October by Afton Historical Society Press. Call Gillette Children's at 612/229-1721 for more information.

Jeremiah Christopher Whitten is a media relations consultant who specializes in health care issues and high technology. He is also a former employee of Gillette Children's Specialty Healthcare.

Alcohol Use in Minnesota

Extent and Cost

Physicians can be a major positive force in preventing and treating alcohol misuse, a widespread problem with alarming social and economic costs.

Doreen Kloehn, M.A., Kimberly J. Miner, Ph.D., Don Bishop, Ph.D., and Kathy Daly, Ph.D.

***Editor's Note**: This article addresses the monetary and social costs of alcohol use and what physicians can do to lower these costs. Minnesota-specific data show that Minnesota has higher rates of binge drinking in young adults than the national average. But what does this mean for traumatic death rates or rates of alcohol-related diseases such as fetal alcohol syndrome in children born to women in this age group?*

Most of the economic costs and mortality data are not Minnesota-specific. The percentages of deaths are based on data collected elsewhere and then applied to Minnesota's overall mortality figures. The results give us only a general idea of what is happening in our state, but the work reported in this paper provides a starting place. Alcohol is an expensive and deadly vice when not used with intelligence, maturity, and common sense (even in the intelligent and mature person). Effective treatment is available, but we must first identify the problem. Do you ask your patients who are older than 10 about alcohol consumption? I didn't until I realized just how difficult it is to identify alcoholism and alcohol-related problems without using a routine set of screening questions.

—Barbara P. Yawn, M.D., M.Sc.
Series Editor

Alcohol is the most widely used drug in Minnesota and is associated with many diseases and injuries. Along with tobacco, poor diet, and sedentary lifestyle, alcohol is a leading contributor to premature death in the United States.[1] In addition, the emotional, social, and economic costs to society are unacceptably high, yet entirely preventable. Physicians play a central role in alcohol abuse prevention, screening, counseling, diagnosis, and treatment among their patients. Their influence also extends into the community and public policy.

The Minnesota Department of Health conducted a study to estimate the extent of alcohol use in our state, the health consequences, and the economic costs. The Health Department estimated that in 1991, nearly 1,600 people in Minnesota died prematurely from alcohol-related causes. These deaths represent the loss of 34,000 years of potential and productive life. The estimated economic cost of alcohol use totaled over $1.7 billion.

The report "Alcohol Use in Minnesota: Extent and Cost," available from the Minnesota Department of Health,[2] details these findings. The report updates a study conducted by the Health Department in 1985 and is intended to help Minnesota's medical and public health professionals and policymakers advance alcohol prevention efforts.[3]

Methods

We estimated the extent of alcohol use in Minnesota using statewide surveys and alcohol sales and shipment data. We calculated alcohol-related mortality and economic cost figures using software developed for the Centers for Disease Control and Prevention.[4] The software incorporates Minnesota population and mortality data, Minnesota economic cost data, and national alcohol-related mortality and cost data proportionately applied to Minnesota. The figures reported here are best estimates based on the most advanced and widely accepted definitions and methods used in alcohol epidemiology and cost-of-illness research.

Prevalence of Alcohol Use in Minnesota

In a 1989 statewide survey, 60% of Minnesota adults (18 years and older) reported drinking alcohol in the previous month. Only 25% smoked cigarettes, 3% used marijuana or hashish, and less than 1% used cocaine during the same period.[5] According to the 1993 Behavioral Risk Factor Surveillance System,[6] adult Minnesotans reported a relatively high prevalence of binge drinking compared with residents of other states (Table 1). Binge, or acute, drinking involves consuming five or more drinks on one or more occasions in the previous month. Binge drinking is most common among young adults (18 years to 34 years) and among men. In 1993, 43% of men and 30% of women ages 18 to 24 reported binge drinking.

Table 1

Binge and heavy drinking in the United States and Minnesota, 1993

Drinking pattern	1993 prevalence (%) U.S. range	U.S. median	Minnesota prevalence
Binge, or acute, drinking (5 or more drinks on one occasion in the previous month)	4.2-22.8	14.2	19.2
Heavy, or chronic, drinking (an average of 60 or more drinks in the previous month)	1.4-6.1	3.0	3.2

Source: Minnesota Department of Health

Heavy, or chronic, drinking in Minnesota in 1993 more closely approximated the national median (Table 1). Heavy drinking involves consuming an average of 60 or more drinks in the previous month. In 1994 and 1995, the prevalence of heavy drinking rose in Minnesota, especially among men.[7]

Table 2

Alcohol-related deaths in Minnesota, 1991

Cause of death	Total deaths (n)	Alcohol-related deaths (n)	Percent (%)
Unintentional injury	1,456	457	31
Cancer	8,375	260	3
Digestive disease	1,140	250	22
Cardiovascular disease	14,639	204	1
Violence	613	193	31
Mental disorders	840	101	12
Respiratory disease	3,464	77	2
Other causes	4,714	38	1
Total	35,241	1,581	4%

Source: Minnesota Department of Health

Deaths Related to Alcohol Use

We based our alcohol-related mortality calculations on estimates of the proportion of deaths that are related to alcohol use. This proportion, termed the alcohol attributable fraction (AAF), has been estimated for diseases, injuries, and acts of violence, based on clinical case series, epidemiological studies, and injury surveillance studies. Total alcohol-related mortality includes all deaths from diagnoses that are alcohol-attributable by definition (e.g., alcohol poisoning, AAF=1.0), and a proportion of other deaths for which alcohol use was a significant contributing factor (e.g., fire deaths, AAF=0.45). We applied these AAFs to Minnesota mortality data to estimate alcohol-related deaths. AAFs may be conservative, given the underreporting of alcohol involvement in diagnoses of disease and injury.

In 1991, approximately 1,581 deaths—4% of all deaths in Minnesota that year—were related to alcohol use (Table 2). Of all deaths statewide from both violence and unintentional injury, almost one in three were linked to alcohol use. More than one-fifth of all deaths from digestive disease were also alcohol-related. Within the broad categories, the leading specific causes of alcohol-related death were, in order of frequency, motor vehicle crashes, stroke, suicide, cancer of the esophagus, and falls.

On average, each alcohol-related death occurred 22 years before full life expectancy. The difference between the expected length of life and the actual age of death is termed years of potential life lost. The 1,581 alcohol-related deaths translate to 34,177 years of potential life lost. Overall, young people account for a disproportionate share of alcohol-related deaths. Children, adolescents, and young adults up to age 34 accounted for only 5% of deaths from all causes in 1991. However, these young Minnesotans accounted for 17% of all alcohol-related deaths in the same year.

Economic Costs of Alcohol Use

The total cost of the consequences of alcohol use in Minnesota for 1991 was estimated at $1.74 billion, or about $400 for each Minnesota resident. This figure includes costs for direct health care, lost productivity, treatment and care resulting from fetal alcohol syndrome, and nonhealth-sector costs (Table 3).

Direct health care costs include expenditures for medical care to treat alcohol-related diseases and injuries, as well as treatment and rehabilitation services for alcohol-related dependence. We used both Minnesota and prorated national data in the calculation. The major-

Table 3

Economic costs of alcohol use in Minnesota, 1991

Cost category	Cost (in millions of dollars)
1. **Direct health care**	$178.6
Treatment	
Hospitals	84.1
Specialty institutions	47.0
Office-based physicians	3.9
Nursing homes	7.5
Professional services	4.8
Federal providers	18.5
Support	
Training, research, net cost of private health insurance, program administration	12.8
2. **Lost productivity**	
Due to alcohol-related disability and impairment	1,285.1
Noninstitutionalized	883.7
Institutionalized	8.1
Due to alcohol-related death	393.3
3. **Fetal alcohol syndrome treatment and care**	44.8
4. **Nonhealth sector**	228.1
Direct costs	
Crime expenditures	91.9
Motor vehicle crashes	55.9
Fire destruction	9.9
Social welfare administration	1.9
Indirect costs	
Lost earnings of crime victims	10.1
Lost earnings from incarceration	58.4
Total	$1,736.6
Cost per person (in actual dollars, not millions):	$400

Source: Minnesota Department of Health

ity of the estimated $179 million direct health care costs was for treating young to middle-aged men.

Lost productivity costs include those attributable to alcohol-related disability and impairment and those attributable to alcohol-related death. Both categories measure the monetary value of individuals' lost productivity related to alcohol use. At $884 million, the 1991 estimated costs due to alcohol-related disability and impairment accounted for 51% of the total cost of alcohol use. These losses resulted from lower occupational achievement and work effectiveness, reduced labor force participation, increased unemployment and part-time work, and lost time related to absenteeism or tardiness.

Lost productivity costs attributable to alcohol-related death are the estimated value of the earnings a person would have gained if he or she had not died prematurely. The figure of $393 million thus reflects the current value of all future earnings that were lost by those who died from alcohol-related causes in 1991. We adjusted the value of future earnings to their current value using a 4% discount rate. The high costs of lost productivity are related in part to the high proportion of alcohol-related deaths among children and young adults.

The costs of fetal alcohol syndrome (FAS) include expenditures for the care and treatment of children and adults with FAS. The major cost components are neonatal intensive care, surgical correction for physical birth defects, and full-time residential and semi-independent care services for youth and adults. The $45 million estimate does not include costs related to remedial education, foster care, or the justice system. It also does not include costs associated with fetal alcohol effects (FAE)—a more common, though often hidden, consequence of prenatal alcohol exposure that includes permanent behavioral disorders.

Nonhealth-sector costs, totaling $228 million, include crime expenditures, nonmedical costs of motor vehicle crashes, fire destruction, social welfare administration, and lost earnings from alcohol-related crimes.

Because of research limitations, these costs should be regarded as "best estimates." The epidemiological limitations, economic assumptions, and categorical definitions that we made greatly affect the estimates. For example, it is difficult to gauge lost productivity, since one can only estimate, not precisely measure, what is not produced.[8] However, we made these estimates with the most current methods available in cost-of-illness studies. Despite the limitations, these estimates can be useful for comparing costs across categories, examining costs by age and gender, and identifying areas for further research and action.

What Can Be Done?

Medical professionals can be a major positive force in preventing and treating alcohol misuse. Physicians can intervene by screening and counseling patients about alcohol use. Valid, sensitive, and specific alcohol screening tools are available for the clinical setting. The Minnesota Medical Association promotes a four-item scale called the CAGE questionnaire (see the February 1997

Monitor in *Minnesota Medicine*, page 37).[9] Some tools have been designed to serve particular patient populations, such as T-ACE, which assesses risk among ob/gyn patients.[10]

Numerous barriers to effective screening and counseling exist, however, including the real constraints on a physician's time, as well as societal and individual ambivalence concerning alcohol use. Recent studies show large discrepancies between what physicians would like to do in screening and counseling and what actually occurs.[11] When the health care delivery system offers more incentives for prevention, the practice of comprehensive, routine preventive screening and counseling will become more widespread.

Contributing to the discrepancies is the consideration that the moderate use of alcohol may actually confer some health benefits.[12] Unlike illicit drugs, alcohol is legal and used widely and, in many cases, responsibly. In the face of the complex array of medical knowledge, social practices, media messages, and public morals about alcohol, the medical community needs to develop and communicate consistent recommendations and practices concerning alcohol. (See the October 1996 *Minnesota Medicine* articles by Miner et al.[13] and Lussky[14] on screening for alcohol use during pregnancy.)

The effects of alcohol use may be subtle, and physicians may not always be aware of how alcohol has contributed to a patient's injury or illness. One example of an attempt to improve alcohol detection is a set of questions on the Minnesota Department of Health Traumatic Brain Injury/Spinal Cord Injury Registry form completed for injury victims seen in trauma centers.

But the physician's influence does not end with the individual patient. Physicians are well respected on health-related matters and can influence community norms and public policies to promote responsible use of alcohol—or abstinence if need be—particularly among young people.

Physicians can become involved in communitywide prevention and treatment on many levels: on community councils and boards, in voluntary organizations, and in educational, workplace, and religious settings. Physicians can provide sound, credible information about the effects of alcohol that will help individuals make responsible decisions. Physicians can also work collectively to promote public policies and practices through their professional organizations. The Minnesota Medical Association House of Delegates has passed numerous alcohol-related policies. In September 1996, the delegates reaffirmed the MMA policy supporting an alcohol excise tax increase, with the intention of reducing alcohol consumption and resulting problems.[15]

Conclusion

Alcohol use in Minnesota leads to many costly consequences, all of them preventable. Physicians play a central role in alcohol abuse prevention, screening, counseling, diagnosis, and treatment among their patients. In the community, physicians can advocate for reducing alcohol-related mortality, illness, and disability, as well as alcohol-related negative social consequences, such as violent behavior and lost work time. Support from the health system and community resources will enhance physicians' efforts to address these problems. MM

Acknowledgment

The authors thank Norbert Hirschhorn, M.D., for his review and comments.

Doreen Kloehn is a research analyst for the Center for Health Promotion at the Minnesota Department of Health. Kimberly Miner is a research scientist for the center and Don Bishop is chief of the center. Kathy Daly is an assistant professor in the Department of Otolaryngology at the University of Minnesota.

REFERENCES

1. McGinnis JM, Foege WH. Actual causes of death in the United States. JAMA 1993;270:2207-12.
2. Minnesota Department of Health. Alcohol use in Minnesota: extent and cost. Minneapolis: Minnesota Department of Health, 1996. (Available in full report [196 pp.] or executive summary [12 pp.], through MDH Center for Health Promotion, 612/623-5548.)
3. Parker DL, Shultz JM, Gertz L, Jensen R, Neider J, Moen ME. Review and cost of alcohol abuse in Minnesota. Minneapolis: Minnesota Department of Health, 1985.
4. Shultz JM, Parker DL, Rice DP. Alcohol-related disease impact software [Computer software and documentation]. Atlanta, GA: Public Health Service, Centers for Disease Control, Epidemiology Program Office, 1989. (Available from Jerry Williams, CSR Inc., tel. 202/842-7600.)
5. Minnesota Department of Human Services. Minnesota household survey of drug and alcohol use among adults. St. Paul: Minnesota Department of Human Services, Chemical Dependency Program Division, 1989. (DHS is currently conducting and analyzing another version of this survey.)
6. Minnesota Department of Health (MDH). 1993 Behavioral Risk Factor Surveillance Survey data provided by the MDH Center for Health Statistics, 1995.
7. Minnesota Department of Health (MDH). 1990-1995 Behavioral Risk Factor Surveillance Survey data provided by the MDH Center for Health Statistics, 1996.
8. Rice DP, Kelman S, Miller LS, Dunmeyer S. The economic costs of alcohol and drug abuse and mental illness: 1985 (DHHS Pub. No. ADM 90-1694). Report submitted to the U.S. Department of Health and Human Services, Alcohol, Drug Abuse, and Mental Health Administration, Office of Financing and Coverage Policy. San Francisco: University of California, Institute for Health and Aging, 1990.
9. Minnesota Medical Association House of Delegates. Resolution 50. Alcohol screening, September 1996.
10. Russell M. New assessment tools for risk drinking during pregnancy. Alcohol Health Res World 1994;18:55-61.
11. Green LW, Kreuter MW. Health promotion planning: an educational and environmental approach. 2nd ed. Mountain View, Calif.: Mayfield Publishing, 1991.
12. De Labry LO, Glynn RJ, Levenson MR, Hermos JA, et al. Alcohol consumption and mortality in an American male population: recovering the U-shaped curve—findings from the normative aging study. J Stud Alcohol 1992;53:25-32.
13. Miner KM, Holtan N, Braddock ME, Cooper H, Kloehn D. Barriers to screening and counseling pregnant women for alcohol use. Minn Med 1996;79:43-8.
14. Lussky RC. Alcohol use during pregnancy: how health care providers can make a difference. Minn Med 1996;79:49-51.
15. Minnesota Medical Association House of Delegates. Resolution 52. Alcohol excise tax, September 1996.

Family Practitioners



Mork Clinic – Anoka

The history...

Mork Clinic provides the people in Anoka and Elk River the best possible health care available. The founder of Mork Clinic, Dr. Frank Mork, established the clinic in 1931, and in 1988, to keep pace with the ever growing community, the clinic expanded to Elk River. The practice now includes 31 physicians with over 150 support staff in a variety of specialties, including Family Practice, OB/GYN, Internal Medicine, Pediatrics, General Surgery, ENT, Gastroenterology, Rheumatology, Allergy, Orthopedics, Nurse Practitioners and Physician Assistants.



Mork Clinic – Elk River

The opportunity...

As our suburban communities grow, we find the need for additional staff. We are seeking Family Practitioners at both the Anoka and Elk River sites to work **flexible full time.** Each physician sees approximately 30 patients on a daily basis, and is supported by a full staff of health care professionals.

The benefit...

Mork Clinic is an independently physician run clinic. Physicians are eligible to become shareholders after working with the clinic for two years. Each shareholder has a stake in how the clinic is run and the types of benefits offered. These positions offer a competitive compensation and benefits package.

The beginning...

Embark on a career journey that is fulfilling and rewarding and become a member of a team of physicians playing an integral part in the community's health and welfare. For further information, please contact Lori Fake at (612) 883-5337 or (800) 472-4695. For consideration, forward your CV to: HealthPartners, Physician Services, PO Box 1309, Minneapolis, MN 55440. You may also e-mail Lori at lori.m.fake@healthpartners.com.

MORK CLINIC P.A.

in affiliation with HealthPartners

EO/AA Employer

Emergency Physician

Locum Tenens Opportunity

HealthPartners Ramsey Clinic has an opportunity for an Emergency Medicine residency-trained, BC/BE Emergency Medicine physician to contract on a temporary basis with our busy Emergency Medicine Department. This temporary, locum tenens opportunity is needed from May-September 1997, or possibly May '97-July '98. Benefits, including malpractice coverage, are available. Salary is competitive.

The position is based at St. Paul-Ramsey Medical Center, a 435-bed primary and tertiary care hospital which is a Level I trauma center, a Level I burn center, a regional poison center and serves as medical control for urban, suburban and rural EMS systems. Our state-of-the-art 31 room emergency facility has an annual census of 57,000, a 20% admission rate and a department staff of 16 emergency medicine faculty, 7 physician assistants, an administrator and support staff.

For consideration, please forward your CV and cover letter to: HealthPartners, Physician Services, Attn: Sandy Lachman, P.O. Box 1309, Minneapolis, MN 55440. Or fax to (612) 883-5395. For more information, call (612) 883-5338 or e-mail: sandy.j.lachman@healthpartners.com. No agencies please.
EO/AA Employer

HealthPartners

St. Paul-Ramsey Medical Center

HealthPartners' mission is to improve the health of our members and our community

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142

E-Mail: stephanie.l.jussila@qm.healthpartners.com

Central Minnesota Group Health Plan

HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220

DID YOU KNOW THAT MMBR'S EMPLOYEE BENEFITS TEAM CAN HELP YOU

BRIDGE THE GAP

Did you know that MMBR, the resource company owned by the Minnesota Medical Association and Hennepin Medical Society, can really help you with the challenges of providing employee benefits?

That's right. Because providing services to medical professionals is our only specialty, you can be sure that MMBR will do a great job in helping you design and obtain quality benefit plans for your practice.



Join the many other medical practices who count on MMBR for employee benefit plans such as:

- ✪ Group medical, dental, disability and life coverage
- ✪ Qualified retirement plans
- ✪ Educational personal finance seminars for your employees
- ✪ Personal financial reviews for physicians and staff
- ✪ Voluntary benefits such as life, disability, and long term care insurance
- ✪ Payroll deduction auto and home insurance
- ✪ Free COBRA administration for MMBR group clients

We work to make bridging the gap convenient and cost effective.

Call Barry Weber or Dan Hagberg today at

800-298-6627

MMBR

Minnesota Medical Business Resources
Owned By MMA & HMS

Special Early Factory Order Pricing on New 1997 Sport Utility Vehicles Through MMBR Motor Services

Remember, whether you purchase or lease, MMBR Motor Services and Creative Leasing, Inc. will help you get the most vehicle at the best price. We'll even help you sell your old auto.

Use your money wisely. For personal attention and lease or purchase information on any vehicle, call 612/623-2860, or toll-free 800/298-MMBR.

MMBR Motor Services is a service of Minnesota Medical Business Resources, a physician-owned corporation of your medical association.

New Vehicle Leases**

Make/Model	MSRP	Your Price*	24 Mo	36 Mo	48 Mo	60 Mo
97 GMC Jimmy SLS 4dr	$27,072	**$24,904**	$433	$376	$337	$320
97 Chevrolet Blazer LS 4dr	$27,482	**$25,251**	$427	$367	$326	$316
97 Ford Explorer XLT 4dr	$28,880	**$26,025**	$432	$376	$341	$318
97 Jeep Grand Cherokee Laredo	$28,188	**$26,149**	$463	$405	$358	$334
97 Nissan Pathfinder SE	$30,618	**$28,268**	$472	$393	$376	$351
97 GMC Yukon SLE 4dr	$32,999	**$31,327**	$486	$438	$403	$384
97 Chevrolet Tahoe LS 4dr	$32,935	**$31,270**	$486	$437	$402	$384
97 Chevrolet Suburban 1/2 LS	$36,457	**$34,293**	$580	$497	$441	$425
97 Toyota 4-Runner SR5 4dr	$31,643	**$30,305**	$516	$434	$386	$359
97 Mitsubishi Montero LS 4dr	$31,690	**$30,361**	$510	$446	$458	$418
97 Ford Expedition XLT 4dr	$33,845	**$31,159**	$436	$396	$379	$361

* Sale price before tax, license, license fees, and 1997 price increase.
** All lease payments listed above are monthly lease payments before tax on factory ordered leases. These lease payments are based on a $0.00 cap reduction and 15,000 miles/year. The only moneys needed to start the above leases are first payment, security deposit, and license for the first year.



MMBR

MOTOR SERVICES

MINNESOTA MEDICAL BUSINESS RESOURCES

OWNED BY MMA & HMS

The Monitor
NEWS FOR MINNESOTA PHYSICIANS

ANNOUNCEMENTS

VISIT MMA HOME PAGE

The MMA Web site includes information on MMA legislation and advocacy, news, a staff directory, links to related organizations, discussion groups, CME information, and links to the best clinical resources, products, and services. Visit the MMA home page at: www.mnmed.org

• • •

MMA MEMBERS APPOINTED TO BMP

The governor has appointed C. Randall Nelms, M.D., a St. Paul otolaryngologist and past president of the MMA, and reappointed Janet Lindquist, M.D., a pediatric general surgeon in Hibbing, to the Minnesota Board of Medical Practice.

• • •

AMA/GLAXO WELLCOME ACHIEVEMENT AWARDS HONOR MINNESOTANS

The following Minnesotans received 1997 AMA/Glaxo Wellcome Achievement Awards at a reception and award presentation on March 15: Edd L. Evans and Jesse A. Goodman, medical students at Mayo Medical School, Timothy H. Olson, a medical student at the University of Minnesota, and Kyle J. Kircher, a resident in family practice. The awards are presented to medical students and resident physicians who have exhibited outstanding leadership abilities in organized medicine, civic or nonclinical medical school, or hospital activities. Award winners are given the opportunity to further develop their leadership skills through participation in AMA's National Leadership Conference.

MMA Mobilizes Support for Reducing 2 Percent Tax

As *The Monitor* goes to press, Minnesota physicians are flooding the governor's and legislators' offices with phone calls, letters, and E-mail messages calling for reduction of the 2 percent tax on health care revenues.

The Minnesota Medical Association's mobilization of grassroots support comes in the wake of an about-face by the governor. In the past, Gov. Carlson's staff has indicated the governor would support some reduction in the provider tax, but on April 10, Morrie Anderson, the governor's chief of staff, told key legislators Carlson would not support any reduction. At the same time, legislators were telling the MMA that they hadn't heard from physicians about the 2 percent tax and they didn't believe it was an important issue.

As support for reducing the 2 percent tax began to unravel, the MMA on April 11 mailed a flyer to all Minnesota physicians—members and nonmembers—urging them to call the governor and their legislators. Physicians responded quickly, sending the governor and legislators hundreds of messages. Calls and letters continue to pour in.

Despite the overwhelming show of grassroots support, MMA attempts to reduce the tax still face a tough battle. As legislators make their preliminary budget decisions, they must consider conflicting demands on how to use the surplus in the Health Care Access Fund, which is partially funded by the 2 percent provider tax. Requests are on the table to increase eligibility for the MinnesotaCare program and to provide some relief for the Minnesota Comprehensive Health Association (MCHA), the state risk pool for people who have been denied private health care coverage for medical reasons. MCHA has a deficit of $42 million. Some legislators are saying there is not enough money to fund MCHA and reduce the provider tax. The Department of Finance's spreadsheets, however, indicate there is enough money to do both.

MMA Calls for Repeal of Surcharge

The MMA is strongly urging legislators to repeal the $400 surcharge on physicians' medical licenses. The issue of whether to repeal the surcharge and how to replace the $4 million per year it raises is part of the overall health care budget discussions. The MMA message is that the surcharge is a selective, inappropriate way to fund state programs. License fees have always been used solely to fund the regulation of the profession and should not be used as a way to raise funds for other purposes. Repeal of the $400 surcharge is included in the Senate version of the MinnesotaCare bill, S.F. 1208-Berglin, which also calls for a meager reduction of the provider tax from 2 percent to 1.75 percent.

Bill Would Repeal Surcharge, Cut Tax, Expand Eligibility

The Senate MinnesotaCare bill, S.F. 1208-Berglin, would repeal the $400 surcharge on physician's medical licenses and reduce the provider tax

MinnesotaCare continued on page 37



Viewpoint

Raymond G. Christensen, M.D.
President, Minnesota Medical Association

MMA Calls for Fair Medicare Reimbursement

As the Clinton administration and Congress consider ways to trim the Medicare budget, the MMA is trying to keep the unfair geographic disparities in Medicare reimbursement in the forefront of their discussions. Change in the Medicare program is inevitable. We are on a collision course. By 2030, Medicare enrollment will have doubled to 75 million while the number of workers paying into the system is expected to drop from 3.8 for every Medicare beneficiary in 1997 to 2.2 per enrollee by 2030.

Proposals under consideration include charging wealthy Medicare recipients higher premiums, shifting home health care spending from Part A to Part B, reducing physician payment updates, encouraging seniors to choose HMOs, introducing new health care plan options, and reducing payments for fee-for-service and managed care plans.

If cuts in Medicare are made across the board, Minnesota and other states with low reimbursement rates will suffer more than other areas. As the Medicare pie gets smaller, Minnesota's piece must not be sliced even thinner.

Minnesota physicians are all too familiar with the problem.

- All Americans contribute the same amount to Medicare through payroll taxes.
- All Medicare beneficiaries pay the same $43.80 per month Part B premium for fee-for-service coverage.
- All Medicare beneficiaries pay the same $100 annual deductible.
- But Medicare beneficiaries' choice, access, and benefits vary widely depending on where they live. So do physician reimbursement rates.

Unfair reimbursement is an old story in fee-for-service Medicare, but unfortunately the disparities are even more egregious in Medicare's managed care system. Medicare managed care rates are based on the national per capita cost of providing fee-for-service care, but this figure is then adjusted to reflect each county's fee-for-service payment rates and utilization. Minnesota and other areas of the country with low fee-for-service Medicare rates and a history of effective utilization and cost controls are penalized. Congress should look for a way to reward states for cost efficiency rather than punishing them.

Across the country, Medicare HMO rates range from Arthur, Nebraska's $220 per enrollee per month to Richmond, New York's $767. (See the map on the facing page.) Medicare HMOs in areas that receive higher reimbursement rates are able to offer their enrollees more comprehensive benefits such as prescription drugs, dental care, and eye glasses, while HMOs in lower reimbursement areas offer only basic services and may even charge extra premiums.

Minnesota has the second lowest average managed care reimbursement rate in the country—$304 per month. Reimbursement in Minnesota counties ranges from $227 in Chippewa County to $422 in Ramsey County. The national average adjusted payment rate is $395. Only five of Minnesota's 87 counties' rates are higher than the national average.

The MMA is working with the Minnesota Congressional delegation and the Geographic Coalition to reduce these geographic variations in Medicare reimbursement. We can count on the support of our Minnesota senators and representatives.

The Geographic Coalition, which was founded by the Minnesota and Utah medical associations in 1989, unites 25 state medical associations to develop grassroots support for correcting geographic disparities and cutting the tie between fee-for-service and managed care reimbursement rates. The coalition states, which send 50 senators and 134 representatives to Congress, increase our leverage on Capitol Hill.

Recently, there have been encouraging signs of support. President Clinton has proposed a $350 floor on Medicare capitated rates. This would help Minnesota, where 75 of the 87 counties receive less than that amount.

The Physician Payment Review Commission (PPRC) recommends reducing the geographic variation in Medicare payments through risk adjustment. HMOs should be paid less for new managed care enrollees, and the payment should be increased as enrollees grow older and need more services, according to the PPRC.

The fight for fairness in Medicare reimbursement is an uphill battle. States that benefit from the current system resist change. Almost all states, however, have rural areas where reimbursement rates are relatively low.

The MMA will continue to press for fair Medicare reimbursement throughout the country. • • • • •

Geographic Coalition Members

Alabama
Arizona
Colorado
Idaho
Indiana
Iowa
Kansas
Louisiana
Maine
Minnesota
Missouri
Montana
Nebraska
New Hampshire
New Mexico
North Dakota
Oregon
Rhode Island
South Carolina
South Dakota
Texas
Utah
Vermont
Wisconsin
Wyoming

• • •

Talk Back

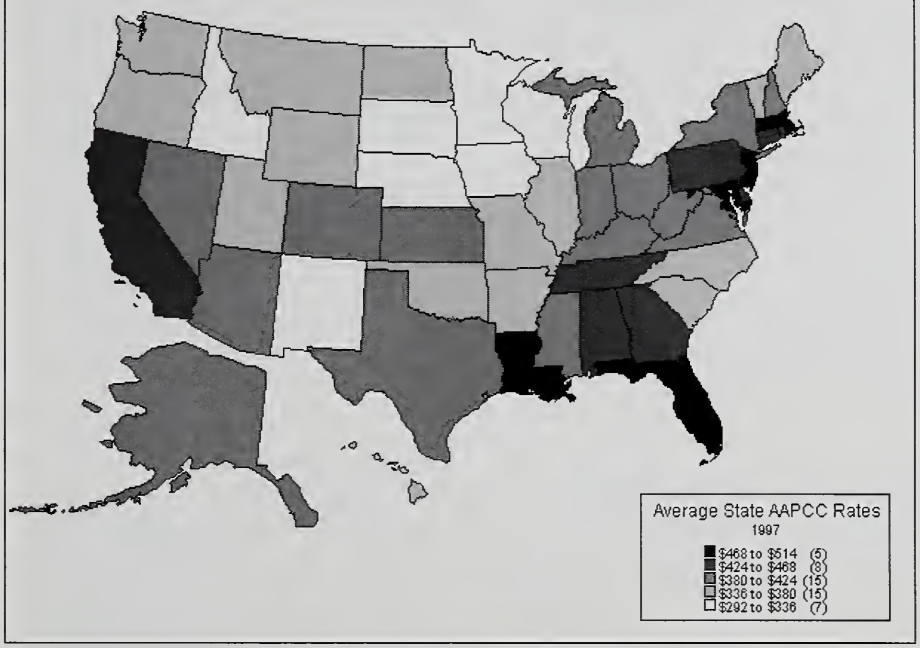
How does Minnesota's Medicare reimbursement rate affect you and your patients? If you have an anecdote that illustrates the effects of Minnesota's Medicare reimbursement rate, *The Monitor* would like to hear from you. Please call Lorrie Holmgren at 612/378-1875, or 800/DIAL-MMA (342-5662) or E-mail to lholmgren@mnmed.org

• • •

Geographic Coalition Is on the Web

The Geographic Coalition's new Web site provides updates on Medicare payment reform and the coalition's strategy for correcting geographic inequity. Visit the Geographic Coalition at www.mnmed.org/gc

Medicare Average Adjusted Per Capitated Costs



Strong Tobacco Licensing Bill Goes to Conference Committee

Legislation to license retail outlets that sell cigarettes and other tobacco products, H.F. 117, has passed the House and Senate and goes to conference committee. The MMA and other members of the Smoke-Free 2000 Coalition support the stronger Senate bill.

The Senate bill includes the following provisions that are not in the House bill:

- Self-service displays for single packs of cigarettes are banned. (The House allows self-service displays but requires them to be in the clerk's line of sight.)
- Two compliance checks a year are required.
- Slotting fees—the practice of paying a retailer to display tobacco products in a prominent place—are banned.
- The drivers' licenses of teenagers using tobacco products on school property could be suspended for 90 days.
- Tobacco companies would be required to report to the Minnesota Department of Health about the presence of any hazardous substance in their products.

Both the House and Senate bills would:

- require retail outlets that sell tobacco to be licensed;
- set fines for the person who sells tobacco to anyone under age 18 and for the license holder; and
- allow local communities to keep their present power to pass more restrictive penalties.

Differences between the Senate bill and its weaker House companion bill will be worked out by the conference committee. The conferees are Sens. Ember Junge, DFL-New Hope, Edward Oliver, R-Deephaven, Deanna Wiener, DFL-Eagan, and Reps. Matt Entenza, DFL-St. Paul, Kevin Goodno, R-Moorhead, and Ann Rest, DFL-New Hope. • • • • •

LEGISLATIVE NEWS

Repeal of Growth Limits Advances

Bills to repeal growth limits for health care providers and to replace the growth limits for health plans with cost containment goals, S.F. 920-Morse/H.F. 858-Huntley, are awaiting action on the Senate and House floors. The MMA is urging lawmakers to pass this legislation. Repeal of the growth limits is one of the MMA's top priorities this session.

Bill Calls for New Direct Contracting Options

Legislation to provide a new option for health care providers and small employers to organize and provide health care is being promoted by Advocates for Marketplace Options for Mainstreet (AMOM). The AMOM bill, S.F. 1568-Kiscaden/ H.F. 1742-Huntley, would allow small employers to organize health care purchasing alliances to buy health insurance for their employees. It also would allow small providers to form networks and contract directly with the alliances. This legislation is consistent with MMA policy supporting many different options for providers to form physician-sponsored organizations. Although the bill will not proceed this session, AMOM is working very hard to amend its provisions onto other legislation.

Senate Passes Exclusive Contract Ban

The Senate passed a patient protection bill that would reinstate the ban on exclusive contracts between health care providers and health plans or other providers, which sunset on January 1, 1997. The MMA has been working closely with the Minnesota Medical Group Management Association and others to reinstate the exclusive contract ban. The MMA's goals are to protect providers from being forced to sign exclusive contracts with large entities and ultimately to preserve choice for patients. "Exclusive contract provisions do not promote competition and in some areas can result in monopoly situations," says David Renner, MMA director of policy and legislation.

The patient protection bill, S.F. 960-Berglin/H.F.1365-Wejcman, would also prohibit gag clauses, require health plans to disclose financial arrangements with providers, set up a consumer assistance office to help with coverage questions, preserve continuity of care, require health professionals to wear name tags, and require health plans to cover emergency care outside the network and outside the service area. The House version of the consumer protection bill is awaiting action in the Health and Human Services Budget Division.

Second Annual
Stop the Violence Day at the Dome

See the Minnesota Twins play the Boston Red Sox
Sunday, May 18, 1997
Music and food vendors on the Plaza at 11:30 a.m.
Game begins at 1:05 p.m.

Sponsored by: Medtronic
Minnesota Medical Association
Minnesota Attorney General Hubert H. Humphrey III
Ramsey/Hennepin Initiatives for Violence-Free Families & Communities
University of Minnesota's Children, Youth, and Family Consortium
WomanKind/Fairview Health System

Cohosted by Minnesota Cable Communications Association, Minnesota Hospital and Healthcare Partnership, Minnesota Nurses Association, Minnesota Council of Health Plans, Citizens Council/Center for Reducing Rural Violence, Allina, Blue Cross and Blue Shield of Minnesota, HealthPartners, Citizens for a Safer Minnesota, Ramsey Medical Society, Hennepin Medical Society, Minnesota Chapter of the American Academy of Pediatrics, and the Minnesota Academy of Family Physicians.

Special half-price tickets are available if purchased in advance. For more information, call Stacy Bjorklund at 612/375-7482.

MinnesotaCare *continued*

from page 33

from 2 percent to 1.75 percent for two years. The House bill, H.F. 1441-Greenfield, would not repeal the surcharge but would permanently reduce the tax to 1.5 percent. The MMA is urging legislators to repeal the surcharge and cut the tax to at least 1.5 percent.

Rep. Fran Bradley, R-Rochester, successfully offered the amendment to reduce the tax from 2 percent to 1.5 percent in the House Health and Human Services Finance Division on April 18. "At 1.5 percent, the tax will raise $20 million more each year than is needed," Bradley said. "If the surplus in the Health Care Access Fund grows too big, it will be too convenient to raid the fund. We want to keep the surplus manageable." Bradley said he would prefer to reduce the provider tax even further.

Rep. Lee Greenfield, DFL-Minneapolis, chair of the committee, said, "The provider tax wasn't the tax the DFL caucus originally wanted. We wanted an income tax increase, but the governor made it clear that if a bill came across his desk with an income tax increase, he wouldn't sign it." Greenfield opposed Bradley's amendment in part because the governor now insists that the Health Care Access Fund be used to create a $150 million reserve fund by the year 2000 to cover losses in federal funding that might occur if there are changes in the Medicaid program. Legislators have been working with the governor to draft a MinnesotaCare bill that won't be vetoed.

Voting in favor of the amendment to reduce the provider tax to 1.5 percent were Reps. John Dorn, DFL-Mankato; Kevin Goodno, R-Moorhead; Bill Haas, R-Champlin; Luanne Koskinen, DFL-Coon -Rapids; Ken Otremba, DFL-Long Prairie; Eileen Tompkins, R-Apple Valley; Barb Vickerman, R-Redwood Falls; and Bradley.

The Finance Division also adopted amendments to repeal the health care revenue growth limits, modify MinnesotaCare eligibility to include some General Assistance Medical Care recipients, and make the Health Technology Advisory Commission advisory to the Minnesota Health Department rather than to the legislature. The bill now goes to the full Health and Human Services Committee.

Provisions in both the House and Senate versions of the MinnesotaCare legislation, S.F. 1208-Berglin/H.F. 1441-Greenfield, would:

- expand MinnesotaCare eligibility to 175 percent of the federal poverty level—$13,808 annual income for individuals and $18,568 for couples—on July 1, 1997;
- create a $150 million federal reserve fund;
- disband the Minnesota Health Care Commission, an advisory committee representing physicians, hospitals, health, plans, nurses, business, and consumers;
- retain the commission's Health Technology Advisory Commission, which issues reports on the costs and benefits of various medical procedures, as an advisory committee.
- provide prescription drug coverage for low-income seniors; and
- restate existing authority to enforce the pass-through of the 2 percent tax on health care revenues by allowing providers to file complaints.

For more information, call Wendy O'Donnell at 612/378-1875, or 800/DIAL-MMA (342-5662). • • • • •

Thank You For Calling!!

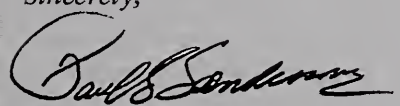
Dear Physician:

Thank you to all physicians who called, wrote, or E-mailed the governor and legislators urging them to repeal the 2 percent tax on health care revenues. The response to our Minnesota Medical Association alert calling for a grassroots effort has been overwhelming.

Your voice does make a difference. Legislators listen to their constituents; they want to know how issues affect the people who live in their district.

If you would like to know the name and phone number of your legislators, call Wendy O'Donnell at the MMA 612/378-1875 or 800/DIAL-MMA (342-5662).

Sincerely,



Paul S. Sanders, M.D.
Chief Executive Officer
Minnesota Medical Association

E-Mail the MMA

• • • • • YOU CAN SEND E-MAIL directly to MMA staff. The E-mail address is: the initial of the person's first name, their last name, followed by @mnmed.org

For example, the E-mail address of the editor of *The Monitor* is: lholmgren@mnmed.org

The E-mail address of the MMA is mma@mnmed.org

LEGISLATIVE NEWS

Naturopath Licensure Bill Pulled

There will be no legislation to regulate naturopaths in Minnesota this session.

After the Senate Government Operations Committee gutted the bill to license doctors of naturopathy under the Board of Medical Practice (BMP), S.F. 523-Berglin/H.F. 396-Wejcman, the bill's authors pulled it from consideration. The Senate committee had deleted all provisions dealing with licensure and replaced them with a provision calling for a comprehensive study of "complementary medicine."

The bill's failure is a blow to those naturopaths who wanted the BMP to license naturopaths who had graduated from an approved naturopathic medical college and passed licensing examinations. A rift within the naturopathic community was responsible for the bill's demise. Self-trained naturopaths who rely on herbal preparations and the body's natural healing powers opposed the bill. Called "mail-order naturopaths" by their critics, these naturo-paths consider those who seek licensure "physician wannabes."

The MMA had opposed several provisions in the original version of the bill that would have allowed naturopaths to perform some procedures that constitute the practice of medicine. The MMA convinced the bill's supporters to remove those provisions, however, and dropped its opposition to the licensing bill.

• • • • • • •

Bill to Allow Professionals to Incorporate Advances

A bill to allow health care professionals from different specialties to form a professional corporation, H.F. 1075-Pugh/S.F. 891-Johnson, has passed the House and Senate. This bill, which would apply to physicians, chiropractors, registered nurses, optometrists, psychologists, and podiatrists, would allow them to form corporations as equal partners. The MMA has historically opposed repeal of the current law banning such corporations because of a belief that care decisions should be made by the professionals providing the care. After MMA amendments were adopted to clarify that this bill does not expand scope of practice, however, the MMA became neutral on the bill. The MMA Board of Trustees recommended that the MMA review its position on the law regarding professional corporations in light of the changing health care marketplace.

• • • • • • •

House Committee Amends Prepaid MA Program Bill

The House Health and Human Services Committee amended the bill, H.F. 1303-Bradley, to require counties that choose to purchase or provide health care under the Prepaid Medical Assistance Program (PMAP) to offer a choice of providers, as well as a choice of health plans or networks. The committee also adopted an amendment stating that if the county becomes insolvent, it can't automatically dump enrollees in the Minnesota Comprehensive Health Association, the state's health insurance program for people who have been denied private coverage for medical reasons. If a county in which PMAP is already operating decides to conduct county-based purchasing, the county must notify enrollees of the change. The committee referred the bill to the finance division. The bill has been incorporated into the House omnibus health and human services bill. The Senate companion bill, S.F. 1230-Samuelson, passed the Health and Family Security Committee as part of the omnibus health and human services appropriations bill.

• • • • • • •

Trial Lawyers Try to Weaken Malpractice Provision

The Minnesota Trial Lawyers Association (MTLA) has been trying to weaken a provision in Minnesota law that is intended to reduce the number of frivolous medical malpractice claims brought to trial. According to current law, before filing a lawsuit in a malpractice case, a plaintiff must file an affidavit certifying that the expert witnesses are truly experts in the field they claim their expertise. This provision was one of the tort reforms passed in 1986.

The trial lawyers are attempting to amend a bill that establishes a similar process for other licensed professionals. Although the bill does not deal with medical malpractice, the MTLA amendment would make it harder for a judge to dismiss a frivolous suit in a medical malpractice case. The MMA strongly opposes these amendments, which would make major changes in a tort system that has worked relatively well for medical cases. According to David Renner, MMA director of policy and legislation, it looks as if the amendment is dead for this year.

• • • • • • •

Senate Weakens Drunk Driving Bill

The Senate dealt a blow to the MMA-supported Mothers Against Drunk Drivers bill, S.F. 77-Marty, by amending it to apply only to repeat offenders. This bill would lower the blood alcohol level that constitutes driving under the influence of alcohol from .1 to .08 percent. According to MADD, approximately 40 lives a year would be saved if the legal limit was reduced to .08. The MMA is urging legislators to pass this important public safety bill. MADD and the MMA are trying to

LEGISLATIVE NEWS

ward off amendments to weaken the House companion bill, which has been incorporated into the omnibus DWI bill, H.F. 1004.

School Start Time Bill Fails

A bill to require Minnesota public schools to start after 8 a.m., S.F. 1300/H.F. 1259, failed to meet committee deadlines and is dead for this session. The MMA supported the bill, which was drafted by the Children's Defense Fund and introduced by Rep. Matt Entenza, DFL-St. Paul and Sen. Sandra Pappas, DFL-St. Paul.

Concern about school start times began three years ago when the MMA wrote to all state school districts, urging them to eliminate early start times for teenagers. Responding to a resolution adopted by the 1993 MMA House of Delegates, the MMA told school superintendents that the timing of the adolescent sleep period is biologically geared to later hours. Teenagers have difficulty falling asleep as early as younger children do and they tend to sleep later in the morning. Adolescents need more than nine and a half hours of sleep—more sleep than younger children or adults.

Although the MMA letter and news release stirred a good deal of discussion, only one Twin Cities school —Edina High School—has actually switched to a later start time. The Minnesota School Board Association opposed the bill because it does not want a new mandate from the state.

Health Care Commission Recommends its Own Repeal

As legislation to eliminate the Minnesota Health Care Commission moves forward, the commission wrote to Gov. Arne Carlson and to several Minnesota legislators recommending its own repeal. The commission believes that many of its goals have been accomplished, including the moderation of health care costs, a decline in the number of uninsured children, and stabilization of the rate of insurance. "We are the victims of our own success," said commission chair John Gunyou. "That's not a bad legacy to leave the state." The letter noted that many policy makers now have differing views and opinions on the most appropriate role and continued value of the commission.

The commission also made the following recommendations.

- The Department of Human Services should develop an education and outreach program for increasing enrollment in the MinnesotaCare program for those who are currently eligible for the program but remained uninsured and the Department of Health and Commerce should continue to reform the small group and individual insurance markets to increase the affordability of insurance products and capitalize on purchasing pool opportunities.
- The Health Technology Advisory Committee (HTAC) should continue to select technologies for assessment in addition to providing scientific information to policy makers on legislatively mandated benefits and accepting assigned duties from the legislature. HTAC should be an advisory committee to the commissioner of health rather than to the legislature as is proposed in the Senate MinnesotaCare bill.
- The state should address the integration of acute, long-term care and chronic care in the near future.

MMA Board Thanks Representatives

As the Minnesota Health Care Access Commission concludes its work, the MMA Board of Trustees on April 5 thanked Jasper M. Daube, M.D., for the excellent job he has done representing the MMA on the commission. The Board also thanked Andrew J. K. Smith, M.D., who served as MMA alternate representative, and Raymond G. Christensen, M.D., who has represented rural physicians on the commission.

ANNOUNCEMENTS

Dr. Jacott's Appointment Is Announced

William E. Jacott, M.D., has been appointed head of the Department of Family Practice and Community Health at the University of Minnesota. For more than a year, Jacott served as the interim head of the department.

Jacott was the first head of family medicine at the University of Minnesota–Duluth School of Medicine, and the first program director of the Duluth Family Practice Residency Program. From 1987 to 1995, he was assistant vice president for health sciences at the University of Minnesota. Jacott has been a member of the American Medical Association Board of Trustees since 1989. He is currently the vice chair for the Joint Commission on Accreditation of Health Care Organization Board of Commissioners. He is also vice chair of the University of Minnesota Physicians Board of Directors.

ANNOUNCEMENTS

Sign Up for MMA Medicare Billing Conference

The Minnesota Medical Association is presenting conferences on compliance with Medicare billing rules during May. The seminars are geared for hospital CEOs, CFOs, compliance officers, office managers, health information management staff, physicians, consultants, attorneys, and anyone else who might be responsible for assuring compliance by clinics and hospitals. The MMA has arranged for David Glaser, J.D., of the Minneapolis law firm of Fredrikson & Byron, P.A., to provide information about compliance programs and to answer questions. Remaining seminars are scheduled for May 8 in Marshall and Sioux Falls, May 14 in Duluth, and May 21 in Fargo. Seminars were held May 1 in St. Paul and May 7 in St. Cloud. The registration fee of $69 includes a continental breakfast. For more information, call Vicki Westling at 612/378-1875 or 800/DIAL MMA (342-5662).

MMA Cosponsors Mayo's Symposium for Women Physicians

The MMA is cosponsoring Women in Medicine: Personal Growth and Professional Development, a symposium for women physicians May 15-17, 1997, at the Mayo Clinic in Rochester. Speakers will address the effects of change on women's health care, the skills needed to lead change, techniques to cope with change on a personal and professional level, communication types and gender differences in communication, assuming leadership roles, balancing work and family, maintaining mental and physical health, and stress management. For more information, call 800/323-2688.

MMA/MMIC Offer Early Detection Conference

Failure to diagnose breast cancer has been identified as a leading cause of malpractice claims. Midwest Medical Insurance Company (MMIC) and the MMA are jointly sponsoring a risk management conference, "Diagnosing Breast Cancer: A Team Approach to Early Detection." The conference will focus on risks of misdiagnosis, proper techniques for screening and evaluation, and the costs of malpractice.

The MMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The MMA designates this educational activity for a maximum of 2.0 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

Holiday Inn, Grand Forks, ND, May 8, 6 p.m. to 9 p.m.

Airport Marriott, Minneapolis, MN, May 20, 6 p.m. to 9 p.m.

The Cornhusker, Lincoln, NE, June 26, 2 p.m. to 5 p.m.

St. Luke's Hospital, Duluth, MN, July 14, 6 p.m. to 9 p.m.

Holiday Inn, Brookings, SD, August 16, 8 a.m. to 11 a.m.

Des Moines Marriott, Des Moines, IA, September 13, 8 a.m. to 11 a.m.

The registration fee is $75; there is no charge to physicians insured by MMIC. For more information call Robin Houlihan at MMIC, 612/922-5445 or 800/328-5532.

Attend the Public Health Forum

You are invited to attend an all-day conference on collaborative efforts between medicine and public health in Minnesota, presented by the Minnesota Medical Association, the Public Health Association, and the Center for Population Health. The conference will be held on Friday, June 13, at the Earle Brown Heritage Center in Brooklyn Center. The keynote speaker is Philip Lee, M.D., the recently retired assistant secretary for the U.S. Department of Health and Human Services. The conference, which is funded by a Robert Woods Johnson grant, will build on the American Medical Association/American Public Health Association "Medicine/Public Health Initiative." For more information, call Janet Silversmith at 612/378-1875 or 800/DIAL MMA (342-5662).

The Monitor
MAY 1997

President
Raymond G. Christensen, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Editor
Lorrie Holmgren

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.

3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Seizures and Spells: Physician Awareness of Minnesota Driving Laws

Kathryn K. Selmo, M.D., Donald S. Asp., M.D., and David C. Anderson, M.D

ABSTRACT

Personal physicians are the primary source of information about state driving regulations for individuals with episodic disturbances of neurologic function (e.g., epilepsy, syncope, hypoglycemia). However, a May 1994 survey of Twin Cities metro-area neurologists and a sample of family practice physicians statewide revealed that many Minnesota physicians are unfamiliar with the relevant laws, and what knowledge doctors have of these laws is influenced by their specialties. Some physicians thought the regulations were more restrictive than they actually are, some less. Even physicians familiar with the laws didn't know which spells should be reported.

Minnesota's driving laws govern the driving privileges of individuals whose ability to operate a vehicle may be temporarily impaired by an episodic neurologic dysfunction, such as seizure, syncope, or hypoglycemia. Physicians' recommendations play an important role in how the state determines driving privileges for these individuals. However, a May 1994 survey of Twin Cities metro-area neurologists and a sample of family practice physicians statewide revealed that many Minnesota physicians are unfamiliar with the relevant laws, and what knowledge doctors have of these laws is influenced by their specialties.

Methods

Our survey tool was a written description of 10 clinical vignettes in which driving privileges are at issue (see sidebar, page 44). For each vignette, physicians were asked to answer a multiple-choice question: "According to Minnesota driving regulations, with physician support, when may this person drive again?" For the first two vignettes, physicians were also asked about reporting the episode to the Department of Public Safety. We defined the "correct" answers based on our interpretation of state driving regulations. Finally, the survey asked respondents to characterize their practices by estimating the number of patients they see each week who have seizures or epilepsy, diabetes, syncope, or other spells.

Results

Fifty-five (45%) of 121 neurologists and 65 (53%) of 108 family physicians responded. As expected, neurologists reported seeing more seizure patients and family physicians more diabetic patients. Results showed no difference by specialty in the number of syncope patients seen each week. The table (facing page) gives the correct answers to the questions and the percentages of correct responses by specialty.

The most important finding is the high rate of incorrect responses by both groups of physicians. The neurologists' higher rate of correct responses is no surprise, since epilepsy, the most recognized episodic disorder for which driving restrictions exist, is well represented in the practices of most neurologists. Similar findings have been reported among British physicians.[1,2] However, most physicians do not recognize that the regulations also apply to other episodic disorders.[2,3] Both syncope and insulin-requiring diabetes, commonly managed by primary care physicians, are more prevalent than epilepsy.[4,5]

Available data show that individuals with these episodic disorders have up to twice the general driving public's rate of traffic accidents and violations.[5,6,7] For perspective, however, only about 1 in 10,000 accidents are attributable to a seizure.[8] And for each accident related to a seizure, 100 are attributable to the combination of male gender and age under 25,[5,9] and 500 are attributable to alcohol abuse.[10]

Discussion

In Minnesota, the patient is responsible for reporting an episode of unconsciousness or impaired control to the Department of Public Safety (612/296-2021). The physician's first responsibility is to inform the patient of this requirement. The physician's second responsibility is to make a written report when the department requests it. In cases of seizures or diabetes, the state provides forms with questions for both patient and

Table

Percent correct responses by family physicians (FP) and neurologists (N)

Question	Answer	FP (*n*=65)	N (*n*=55)
Vignette 1: first seizure			
1. When can patient drive again?	now	12	45*
2. Who reports?	patient	47	93*
Vignette 2: second seizure			
1. When can patient drive again?	6 months	45	90*
2. When must episode be reported?	within 30 days	46	67*
Vignette 3: alcohol-related	1 year	22	16
Vignette 4: late recurrence	now	14	20*
Vignette 5: medicine change	now	17	42*
Vignette 6: nocturnal only	6 months	41	65*
Vignette 7: warning aura	6 months	44	85*
Vignette 8: hypoglycemia	now†	49	35
Vignette 9: complex partial	6 months	35	80*
Vignette 10: simple partial	now	68	93*

*FP vs. N different, $p<0.05$
†using pre-1993 rules: FP, 25% correct; N, 53% correct (FP vs. N different, $p<0.05$)

physician. For other episodic disorders, the state requests a letter from the physician. The commissioner of public safety has the authority to cancel driving privileges if the patient's condition is misrepresented or not reported. The report may be made when the individual applies for a driver's license or, if the individual already has a license, within 30 days of the qualifying episode. The rules do recognize that physicians may not inform their patients of the reporting requirements. Hence, penalties are not exacted unless the patient "had reason to know."

In the rare case of a patient who is a clear danger to the public, who will not self-report, and who continues driving, the physician is encouraged to report directly. Reporting such cases is exempt from patient-physician confidentiality laws;[11] however, physicians are not penalized for failing to report under these circumstances. The reporting laws of most states are similar to Minnesota's, although a few states (California, Delaware, Nevada, New Jersey, Oregon, and Pennsylvania) require physicians to report.[12] Studies have shown that physician reporting discourages patients from disclosing poor control, thereby reducing a physician's opportunity to intervene medically.[13] Under either reporting system, insurance carriers are often not informed.[14,15]

Minnesota rules imply that physicians should report every spell in which there has been "inability to assume or maintain an upright posture without support or inability to respond rationally to external stimuli," regardless of the time in life or circumstances. In our practice, we do not always recommend reporting long-ago provoked or symptomatic episodes for which the precipitant or predisposition is no longer in effect.* We also carefully evaluate with the patient the reportablity of most current spells of uncertain nature. We do differentiate for current symptomatic spells. If the underlying process is likely to continue to be a factor—a seizure related to a brain tumor—we suggest reporting. However, we may not recommend reporting if the predisposition is likely to be resolved definitively—a faint during a gastrointestinal bleed, for example. We recommend reporting first unprovoked seizures whether symptomatic or idiopathic and recurrences in patients with established epilepsy, even when there are grounds for recommending continued driving. Although seizures related to chemical abuse are technically provoked in nature, we advise that they be reported. We document our discussion in the patient's chart.[16,17]

*Provoked episodes are those caused by an immediate precipitant, and symptomatic episodes occur in the presence of an underlying predisposition.

Ten clinical vignettes in which driving privileges are at issue

Vignette 1: A 26-year-old high school teacher who drives to work daily is evaluated in your clinic after her first generalized tonic-clonic seizure. She is otherwise healthy and has no history of unexplained spells or seizures.

According to Minnesota driving regulations, with physician support, when may this person drive again?

A. Now
B. Six weeks
C. Six months
D. One year
E. Other (specify) _____

According to Minnesota driving regulations, who, if anyone, is responsible for reporting this episode to the Department of Public Safety?

A. The physician
B. The patient
C. Both physician and patient
C. Does not need to be reported
E. Other (specify) _____

Vignette 2: A 44-year-old carpenter with a history of generalized seizures due to head trauma at age 18 is seen in your office. His last seizure was one week ago and, before that, eight months ago.

According to Minnesota driving regulations, with physician support, when may this person drive again?

A. Now
B. Six weeks
C. Six months
D. One year
E. Other (specify) _____

According to Minnesota driving regulations, when must this recent episode be reported to the Department of Public Safety, if at all?

A. Does not need to be reported
B. At the time of next license renewal
C. Within 30 days
D. Within 6 months
E. Other (specify) _____

(Vignettes 3-10 ask respondents when the person may drive again: now, six weeks, six months, one year, or other.)

Vignette 3: A 21-year-old college student is evaluated by you one day after his second generalized seizure in two years. His last seizure occurred after a weekend drinking binge, and he was drinking heavily prior to his first seizure. He is otherwise healthy.

Vignette 4: You have been caring for a 60-year-old dentist with a history of focal onset seizures with secondary generalization. After four years without a seizure, he experiences a recurrent seizure.

Vignette 5: A 41-year-old salesperson with complex partial seizures due to a temporal lobe lesion achieves excellent control on Dilantin (phenytoin) but does not tolerate the side effects. One week after you start him on Tegretol (carbamazepine), he has a recurrent seizure. His last seizure was nine months ago.

Vignette 6: A 35-year-old nurse has experienced three generalized seizures in the last three months. The episodes have occurred only during his sleep.

Vignette 7: A 53-year-old attorney is evaluated for new onset seizures. Within the last six weeks, she has had three generalized seizures. However, they are always preceded by mild nausea and a "buzzing" sensation in the back of her head. These warning symptoms have always allowed her to reach a safe place and avoid injury.

Vignette 8: A 32-year-old surgery resident with insulin-dependent diabetes is seen by you for three spells of loss of consciousness in the last month. You determine that all of her spells were insulin reactions. She is otherwise healthy.

Vignette 9: A 39-year-old security guard is seen in your office for the complaint of spells. His friends have told him that at least twice in the last three weeks he has been unresponsive to their questions for several minutes. He remains upright, and his eyes are open but "glazed over."

Vignette 10: A 30-year-old computer programmer complains of burning and tingling beginning in the right foot, marching up his right leg, spreading to his right arm and then his face. It resolves over three to five minutes. He has had six identical spells within the last two months. He denies any other symptoms.

Health Sciences & Human Services Library

The commissioner of public safety decides a patient's driving privileges when the rules are clear, and relies on a physician's written recommendation when there is room for discretion. The process does allow for appeal when a specific rule restricts driving but patient and physician believe grounds exist for requesting variance. The Department of Public Safety makes available on request a more detailed variance request form. The Medical Review Board, a committee of physician experts in episodic disorders, decides these cases.

What State Law Requires

Minnesota rules require that an individual with a first unprovoked seizure(see vignette 1 in the sidebar) report the episode within 30 days, but the rules make allowance for the patient to continue driving if his or her physician so recommends. Such episodes recur in about half of cases. These patients qualify for a diagnosis of epilepsy. For the other half, the seizure is an isolated event. Patients with first unprovoked seizures are often not started on anticonvulsant medication in Minnesota, but the same rules apply to both situations. Because any suspension would date to the time of the seizure, and because any recurrence is most likely to happen soon after the first episode, we recommend that the patient not drive until after a six-week medical followup. This also gives the patient time to obtain the appropriate form from the Department of Public Safety. We generally recommend no suspension of privileges for an individual with a truly unprovoked and idiopathic first seizure.

A patient who has established epilepsy and has a driver's license must report a recent episode within 30 days (see vignette 2). Driving privileges are then suspended until six months have passed without recurrence. Most driving regulations use such an interval to indicate that the condition is controlled or dormant. Minnesota's six-month requirement is about average. Wisconsin's requirement is three months, based on evidence that the predictive power of three event-free months is about the same as six event-free months.[17,18,19] A recent consensus statement from the American Academy of Neurology, American Epilepsy Society, and Epilepsy Foundation of America also recommends three months.[20] We would advise the patient to complete another medical evaluation form from the Department of Public Safety when six recurrence-free months have elapsed.

When chemical abuse causes recurrent seizures (see vignette 3), Minnesota suspends driving privileges for one year. Incidentally, the physician may recommend no interruption in driving after a first seizure related to alcohol or other drug abuse, as in the case of an initial unprovoked seizure. However, we recommend that the individual complete another medical evaluation form after one year without recurring episodes. We do not know whether the state could withhold privileges if substance abuse continued but the patient had no recurrence of seizures.

Minnesota rules give physicians prerogative to recommend no interruption in driving even though a seizure has occurred in an individual with established epilepsy (see vignettes 4 and 5). Consider a patient who has a seizure as a result of a medically supervised change in a successful program (see vignette 4). When physicians discuss changing or discontinuing a patient's anticonvulsant medication when medically indicated, it is helpful to explain that any resulting episodes will be "forgiven." In some cases, physicians may recommend leniency because the patient has had a four-year event-free interval (see vignette 5). In these circumstances, physicians should determine the cause of the breakthrough seizure before recommending uninterrupted driving. In both cases we recommend that the patient report the episode.

Some of Minnesota's rules do not provide leniency (see vignettes 6 and 7). Exclusively nocturnal seizures and seizures with consistent auras providing ample forewarning are not excused from the usual provisions. Elsewhere, as in Great Britain, these circumstances are considered grounds for exemption from driving restriction.[21] The consensus paper alluded to above also recommends that these circumstances be considered bases for variance.[20]

Before March 1993, Minnesota regulations treated episodes of loss of consciousness or voluntary control caused by hypo- or hyperglycemia in insulin-treated diabetes (see vignette 8) in the same way they treat seizures in patients with epilepsy. Under the new regulations, insulin-treated diabetics must report upon applying for initial licensure or, if already driving when diagnosed, within 30 days of diagnosis. However, unlike the situation in epilepsy and other mechanisms resulting in loss of consciousness or voluntary control, episodes that occur thereafter in settings other than driving need not be reported. Those that do occur while driving, like all epileptic episodes, must be reported within 30 days. And only episodes occurring behind the wheel are grounds for a six-month suspension of privileges. Medical guidelines that favor tightened control of blood sugar may increase the likelihood of hypoglycemic episodes, arguing for careful patient education.[22]

Only epilepsy and diabetes are mentioned by name in the Minnesota rules, the scope of which is meant to include all who "have experienced a periodic loss of consciousness or voluntary control." We have assumed that syncope, regardless of mechanism, would be covered in the wider intent of the rules. In fact, sudden death, presumably from cardiac arrhythmia, is about as common a cause of automobile accidents as a seizure due to epilepsy.[17] Minnesota is one of 42 states having no specific regulations for individuals at risk for fatal arrhythmia.[3]

A patient with partial complex seizures (see vignette 9) does not convulse or lose postural control but is not in "voluntary control during the episode." Hence the episodic condition would be considered as though the spells were generalized convulsive seizures. Partial complex episodes, in fact, are overrepresented among seizure types associated with automobile mishaps.[8,23] Some individuals have partial simple seizures

(see vignette 10), meaning they are aware throughout the episode. Many, if not most, individuals with simple partial epilepsy are unimpaired during their episodes and need not report. If an individual's voluntary control might be impaired by a simple motor seizure, that person's physician should determine the need to report.

Conclusion

Minnesota's rules regarding driving privileges for individuals with episodic disorders are for the most part well-conceived and clear-cut. However, they depend on well-informed physicians. The results of our survey indicate that many physicians are not familiar with the laws. Gray areas, particularly with regard to reporting, often result in the laws being applied inconsistently.

We speculate that qualifying disorders are considerably underreported. For example, Minnesota has approximately 4,300,000 citizens and 3,100,000 drivers. Since the prevalence of epilepsy is approximately 1%, the state has at least 31,000 potential drivers with epilepsy. Since about 70% of adult epileptics have prolonged remission,[24] 20,000 or so should be able to drive legally. The state has only about 8,000 drivers registered as having any type of episodic disorders (diabetes, syncope, seizures, etc.).[25] Consequently, many epileptics qualified to drive and many individuals with other episodic disorders are either not driving or have not reported their condition. MM

Acknowledgment

The authors gratefully acknowledge the participation of the neurologists and family practitioners who responded to the survey, the statistical assistance of Scott Lenz of the Minneapolis Medical Research Foundation, the editorial advice of James Kaufmann, and the suggestions of the following physician experts: Terry Capistrant, Greg Cascino, John Gates, Fred Langendorf, Ilo Leppik, and Joanne Rogin.

Kathryn Selmo is currently with the Noran Neurological Clinic PA. Donald Asp is with the Bethesda University Family Practice Clinic and is associate professor of family practice and community health at the University of Minnesota Medical School. David Anderson is chief of neurology at Hennepin County Medical Center and professor of neurology at the University of Minnesota Medical School. (This research was carried out while Dr. Selmo was a resident in the University of Minnesota Affiliated Neurology Program.)

REFERENCES

1. Harvey P, Hopkins A. Views of British neurologists on epilepsy, driving, and the law. Lancet 1983;1:401-4.
2. King D, Benbow SJ, Barrett JA. The law and medical fitness to drive—a study of doctor knowledge. Postgrad Med J 1992;68:624-8.
3. Strickberger SA, Cantillon CO, Friedman PL. When should patients with lethal ventricular arrhythmia resume driving? an analysis of state regulations and physician practices. Ann Intern Med 1991;115: 560-3.
4. Spudis EV, Penry JK, Gibson P. Driving impairment caused by episodic brain dysfunction: restrictions for epilepsy and syncope. Arch Neurol 1986;43:558-64.
5. Hansotia P, Broste SK. The effect of epilepsy or diabetes mellitus on the risk of automobile accidents. N Engl J Med 1991;324:22-6.
6. Waller JA. Chronic medical conditions and traffic safety: review of the California experience. N Engl J Med 1965;273: 1413-20.
7. Hansotia P, Broste SK. Epilepsy and traffic safety. Epilepsia 1993;34:852-8.
8. Van der Lugt PJM. Traffic accidents caused by epilepsy. Epilepsia 1975;16: 747-51.
9. Devinsky O, Hughes JT. Legal aspects of epilepsy. Neurol Clin 1994;12:203-23.
10. Tettenborn B, Kramer G. Total patient care in epilepsy. Epilepsia 1992;33(Suppl 1):s28-s32.
11. Capistrant TD. The driver with epilepsy. Minn Med 1984;67:91-3.
12. Krumholz A. Driving and epilepsy: a historical perspective and review of current regulations. Epilepsia 1994;35:668-74.
13. Salinsky MC, Wegener K, Sinnema F. Epilepsy, driving laws, and patient disclosure to physicians. Epilepsia 1992;33:469-72.
14. Stevens AB, Roberts M, McKane R, Atkinson AB, Bell PM, Hayes JR. Motor vehicle driving among diabetics taking insulin and non-drivers. BMJ 1989;299: 591-5.
15. Dickey W, Morrow JI. Epilepsy and driving: attitudes and practices among patients attending a seizure clinic. J R Soc Med 1993;86:566-8.
16. Masland RL. The physician's responsibility for epileptic drivers. Ann Neurol 1978;4:485-6.
17. Krumholz A, Fisher RS, Lesser RP, Hauser WA. Driving and epilepsy: a review and reappraisal. JAMA 1991;265:622-6.
18. Kuhl V, Kiorboe E, Lund M. The prognosis of epilepsy with special reference to traffic security. Epilepsia 1967;8: 195-209.
19. Hansotia P. Epilepsy and driving regulations in Wisconsin. Epilepsia 1994;35:685-7.
20. American Academy of Neurology, American Epilepsy Society, and Epilepsy Foundation of America. Consensus statements, sample statutory provisions, and model regulations regarding driver licensing and epilepsy. Epilepsia 1994; 35:696-705.
21. Shorvon S. Epilepsy and driving: British regulations have recently been eased [editorial]. BMJ 1995;310:885-6.
22. Ehrlich EN. Diabetes and the license to drive. Wis Med J 1991;90:115-8.
23. Gastaut H, Zivkin BG. The risk of automobile accidents with seizures occurring while driving: relation to seizure type. Neurology 1987;37:1613-6.
24. Annegers JF, Hauser WA, Elveback LR. Remission of seizures and relapse in patients with epilepsy. Epilepsia 1979;20:729-37.
25. Palas J, Gates JR. Epilepsy and driving (abstract). Epilepsia 1994;35(Suppl 8):s107.

The Right Prescription for Long Term Care Insurance

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED

The ABC's of Long Term Care Insurance: the physician as the ***Advisor*** to their patients, a potential ***Buyer*** of the product, and in many cases the designated ***Caretaker*** within their own family. The Minnesota Medical Association recognizes your request for education, information, and service on this topic and MMBR has developed a program to help you answer the questions being asked by your patients and your parents! It also lets members, spouses, parents, and parents-in-law purchase this type of coverage for up to ***20% off standard rates!***

For information on the MMA program, a schedule of educational workshops, or a private consultation for you or your family members, call MMBR at ***612-623-2860 or 800-298-6627.***

ROBERT K. SMITH, M.D.
2424 Main Street East
Anytown, MN 55505
(612) 555-1212

NAME _____

ADDRESS _____

℞

MMBR

INSURANCE SERVICES
MINNESOTA MEDICAL BUSINESS RESOURCES
OWNED BY MMA & HMS

TravelersInsurance
A Member of TravelersGroup

MMA
MINNESOTA MEDICAL ASSOCIATION
MEDICINE'S VOICE IN MINNESOTA

This plan is administered for the members of the Minnesota Medical Association by:

Newman Financial Services

NFS

Members of the Minnesota Medical Association are saving money on their workers' compensation insurance premium costs with the Dodson Plan!

Minnesota Medical professionals were paid a 15% dividend totaling more than $148,000.00 in 1996! In fact, participating members have received dividends 21 out of 25 years with Dodson Group!

In addition to yearly dividend opportunities, MMA members receive:

COMPETITIVE RATES. A 15% discount is applied when policies are issued.

PERSONALIZED SERVICE. Our home office and field staffs are experienced and professional. They work closely with you, addressing your questions and concerns.

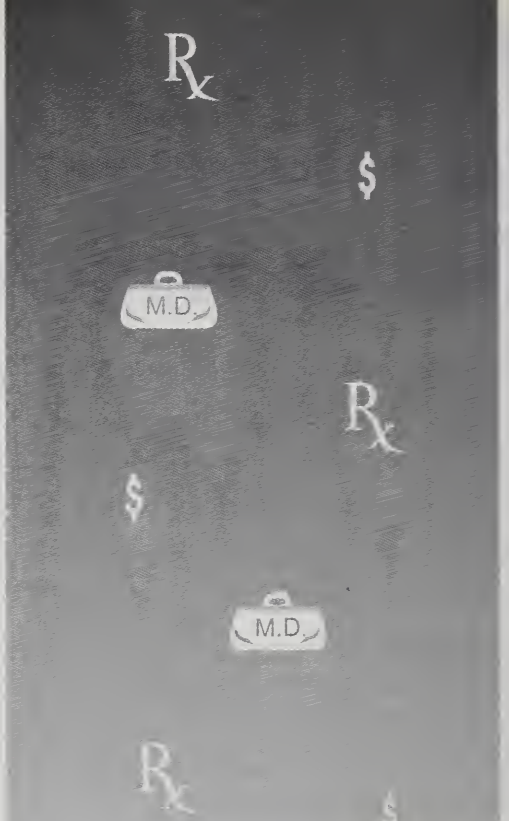
INTEREST-FREE PAYMENT PLAN. The Plan is designed to give you flexibility in paying your insurance premiums with interest-free installments!

OUTSTANDING CLAIMS MANAGEMENT. Our progressive managed care program gives you access to two of the largest PPO networks in the country.

A CENTURY OF EXPERIENCE. Dodson Group insured its first customer in 1900 and its first MMA members in 1972! Today, that experience works for you!

DODSON GROUP

*State laws prohibit insurance companies from guaranteeing future dividends.



Get the Facts!

MMA members can receive a free no-obligation premium quote . . . just call or FAX Dodson Group today!

CALL: 1-800-825-9489
FAX: 1-800-825-6035

Visit our Web site: http://www.dodsongroup.com

PHYSICIAN APPROVED MMBR ASSOCIATION ENDORSED

Dodson Group has been the preferred provider of WC insurance of the Minnesota Medical Association since 1972.

Is Direct Contracting the Business of Insurance?

Recent regulatory pronouncements fail to clarify when health care provider risk sharing will be regulated as insurance.

Margo S. Struthers, J.D., and Paul D. Anderson, J.D.

Minnesota health care providers assuming risk are confronted by conflicting regulatory precedent that provides no clear guidance regarding when risk assumption will be regulated as insurance. Following are two examples of the confusion.

A corporation contracts with individual Minnesota physicians to provide malpractice legal defense services to the physicians. In exchange for a physician's monthly payment of $15, the corporation promises to pay for legal counsel to defend the physician against malpractice actions in an amount up to $5,000 for a single claim and up to $10,000 in the event of two or more claims.

Almost a century ago, the Minnesota Supreme Court ruled that this situation *was* insurance and *should* be regulated.[1]

An employer coalition contracts with a "care system," consisting of primary care providers as well as affiliated specialists, hospitals, and allied professionals, to arrange for the provision of a certain defined set of health care services to the employees of the coalition's employer members. Under the contract, the care system agrees to provide or arrange for the provision of health care services to employees of the coalition's employer members in exchange for paying a specific monthly amount per employee to the care system.

Minnesota's commerce commissioner recently indicated that this arrangement, which the Buyers Health Care Action Group (BHCAG) developed and which involves providers undertaking risk, would *not* be regulated by insurance.[2]

A clinic offers a prepaid health plan under which it provides a broad range of health care services to an enrollee in exchange for the enrollee's payment of a monthly fee based on income.

The Minnesota Department of Health determined this arrangement meets the definition of insurance under state law and provided the clinic with two options: 1) to become licensed as a CISN or HMO, or 2) to eliminate the prepaid plan. The clinic elected to terminate the plan.[3]

These situations have a number of elements in common:

- one party, in exchange for predetermined consideration, agrees to provide a particular service to another party for a period of time;
- the service will be provided to the recipient in response to an adverse event; and
- the pricing of the services includes an element of underwriting risk. Specifically, the person agreeing to provide the service prices the service upon an "assumption" that not all persons covered by similar contracts will use the services contracted for.

The fact that two situations were regulated as insurance while the other currently is not highlights the uncertainty today regarding direct contracting under Minnesota law.

This article describes recent developments in the evolving regulation of insurance in Minnesota, including BHCAG's direct contracting arrangement and the Direct Contracting Report, issued in final form by the departments of Health and Commerce in January 1997.

What Is Direct Contracting?

Direct contracting involves arrangements in which health care providers contract directly with employers to provide health care services to persons covered under the employers' health benefits plans. Under recent direct contracting arrangements, providers are more frequently assuming risk for utilization of services by capitation or some other form of risk sharing. Minnesota's health and commerce departments are concerned that such arrangements involve providers in the business of insurance.

Insurance Regulation in Minnesota

States are primarily responsible for regulating insurance,[4] which Minnesota law describes as "any agreement whereby one party, for a consideration, undertakes to indemnify another to a specified amount against loss or damage from specified causes, or to do some act of value to the assured in case of loss or damage."[5]

Historically, Minnesota insurance laws have been interpreted to prohibit provider assumption of risk for service utilization; that is, the risk that persons for whom health care services are provided may require

more health care services than anticipated, unless they are licensed as an insurance company, nonprofit health service plan corporation, HMO, CISN, or other authorized health plan company.[6]

The Minnesota Legislature created a limited exception to this general rule in 1995, and again in 1996, when it authorized provider cooperative demonstration projects[7] through which three different provider cooperatives are permitted to assume limited risk under direct contracts with self-insured employers.* The financial risk is limited to 50 percent of a self-insured employer plan's expected annual costs. The law also established stop-loss coverage requirements that increase as the size of the employer decreases. Significantly, this legislation represents the first time that Minnesota law expressly authorized limited provider risk sharing in direct contracts with employers.

Buyers Health Care Action Group

BHCAG is a coalition of large self-insured Minnesota employers that facilitates the purchase of health care services. Effective January 1, 1997, BHCAG, on behalf of its employer members, entered into contracts with provider "care systems" that agreed to provide a defined set of health care services to employees and dependents of BHCAG's employer members. Under the contracts, care systems are paid on a modified fee-for-service basis. Fees are adjusted quarterly if the total cost of services in the preceding quarter, measured on a per member per month (pmpm) basis, is less than or exceeds a pmpm target established by the care system and BHCAG for individuals and families. A care system generally receives an amount equal to the pmpm target, multiplied by the number of employees enrolled with the care system.

In 1996, the Commerce Department reviewed BHCAG's payment mechanism. In an October 8, 1996, letter to BHCAG, the commerce commissioner stated that he would not regulate the arrangement, despite his conclusion that care systems assume "substantial risk" of reduced payment for services rendered in the event of increased utilization.[2]

The commissioner qualified his decision by noting that "we would not hesitate to attempt to define your [BHCAG's] program as insurance if we felt the rationale for regulation was being violated." He cited two factors for declining to regulate: 1) the existence of a risk-adjustment mechanism in the payment system (to protect providers against adverse consequences arising from high-risk or special-needs populations), a mechanism normally considered an indicia of insurance, and 2) the large size and substantial resources of BHCAG employer members, which provide some assurance that they will maintain their commitment to provide health care services to their employees if a care system were to become insolvent.

Noting that not every employer would be able to protect its employees in the event of care system insolvency, the commissioner also stated that the Commerce Department would attempt to develop minimal regulation with enough flexibility to encompass change, but with adequate protection for the public.

The Direct Contracting Report

Meanwhile, the 1996 Minnesota Legislature had requested the commissioners of commerce and health to study "the feasibility of allowing direct provider contracting of health care services." Out of the study came the Direct Contracting Report, which discusses direct contracting issues, health plan financial solvency issues, Health Department oversight of health plans, and Commerce Department oversight of insurance companies and nonprofit health service plan corporations.

The commissioners presented four conclusions about direct contracting for legislative consideration:

1. Allowing risk sharing between provider service organizations (PSOs) and employers is feasible;

2. Direct contracting between PSOs and employers, where the PSO assumes risk, is the business of insurance, and, in order to protect the public, will need to be regulated by the state to protect the public;

3. The state needs to clarify whether a PSO that assumes any amount of risk will be considered to be in the business of insurance, or whether a threshold exists below which risk sharing will not require regulation; and

4. Regulation of PSOs should be based on, though not necessarily identical to, current regulation of HMOs and CISNs because of their similarity. Limited services organizations (vision care only, for example) may be regulated less extensively.

The Direct Contracting Report recommends that the following regulatory principles be applied in designing a regulatory framework for risk-sharing PSOs:

- To the extent possible, health plans should operate on a level playing field. That is, organizations that offer similar services should be regulated similarly. The recommendations would regulate PSOs in a manner similar to other licensed health plans.
- The primary goal of state regulation is the protection of consumers.
- Regulation should interfere as little as possible with the operation of the market.

A draft of the report was made public early in December. Response was mixed. Payers and consumer protection advocates supported the general recommendations. In contrast, physician groups, hospitals, and self-insuring employers were concerned that the recommendations might stifle innovation in the marketplace. They also felt the report failed to adequately address ERISA implications and that it did not prescribe clear guidance about when risk-sharing arrangements that result in PSOs assuming risk should be regulated. Finally, they argued that the draft report erroneously concluded that PSOs are assuming insurance risk (rather than "service" or "business" risk) when direct contracting with self-insuring employers.

The final report, dated January 31, 1997, was not substantially mod-

*Quality Health Alliance, Minnesota Rural Health Cooperative, and Southwest Minnesota Health Alliance.

ified to reflect these concerns. However, it was amended to reflect the commerce and health departments' belief that current Minnesota statutes and regulations are sufficient to enable them to regulate the business of insurance. The report also recommended that the Legislature, before adopting any new laws, determine why providers have not been interested in taking advantage of previous legislation designed to facilitate new health care service delivery options, such as CISNs and provider cooperatives.

ERISA and Direct Contracting

The Direct Contracting Report touches on ERISA implications, but they merit more attention. State insurance laws cannot be used to regulate self-insured ERISA plans. While ERISA does not affect the authority of states to regulate insurance, it does provide that an ERISA plan will not be "deemed" to be an insurance company or engaged in the business of insurance for the purpose of state regulation.

Certain proponents of direct contracting risk-sharing arrangements argue that the employers in such arrangements are taking "insurance" risk, and that, accordingly, the employers and not the providers should be the focus of regulation. The significance of ERISA to this argument is that states have no authority to regulate the employers. This means that any state insurance regulation of direct contracting arrangements must be based on the regulation of a provider if it is engaged in insurance.

When a state declines to regulate direct contracting arrangements as insurance, the consequences are potentially significant for participants in the self-insured plan. ERISA regulation of these plans provides few substantive protections to plan participants, especially when contrasted with state-regulated insurance. In the context of provider risk-sharing arrangements, ERISA's significant shortcomings are:

- ERISA imposes no solvency requirements on employers or providers or others with whom providers share risk. If the provider becomes insolvent, plan participants could lose access to health care services.
- If participants are denied benefits, they may be subject to administrative remedies under a plan that, when contrasted with remedies available under state insurance laws, may be inadequate or more costly and time-consuming.
- An individual who has been harmed by a denial of benefits often is unable to obtain damages.

Conclusion

When will the state regulate direct contracting arrangements as insurance? Neither the Direct Contracting Report nor the commerce commissioner's letter to BHCAG provides a clear answer. Both acknowledge the potential for unregulated provider risk sharing. Barring a new Minnesota statute regulating PSOs, the regulation of direct contracting

HIKE ON THE NORTH SHORE... IN THE WOODS OR WITH YOUR WOODS



SOME PEOPLE HIKE in the woods with a set of clubs, others just like to hike in the woods. What ever your choice — Cascade Lodge or Superior National Golf Course are the places to enjoy. Cascade Lodge has cabins, lodge rooms, some with whirlpools, fireplaces, porches and a great family restaurant. Call us with your plans and let us show you how you can play in the woods.

CASCADE LODGE

3719 W. Hwy 61
Lutsen, MN 55612

1-800-322-9543 / 218-387-1112

www.cascadelodgemn.com

ASPEN Medical Group

Internal Medicine
Family Practice
Full Time Urgent Care

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

HUDSON PHYSICIANS

FAMILY PRACTICE

Hudson Physicians, a fast-growing primary care clinic located in Hudson, Wisconsin, nestled in the scenic St. Croix River Valley, is seeking physicians to join our group of 12 .

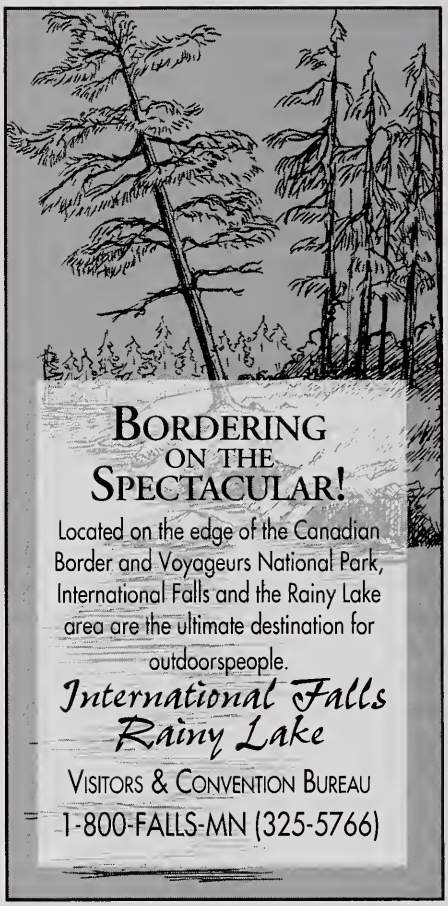
Located 15 minutes from St. Paul, Minnesota, Hudson Physicians offers the best of both metropolitan access and outreach/rural family qualities that enhance both practice and lifestyle.

Excellent salary guarantees, benefits and opportunities.

Please contact:
Steven L. Muellerleile, Administrator
Hudson Physicians, Inc.
402 Wisconsin St.
Hudson, WI 54016

HUDSON PHYSICIANS

A division of Western Wisconsin Medical Associates S. C.



North Central Medical Conference

Presents Two Exciting Tours From Minneapolis/St. Paul



SWITZERLAND AND GERMANY

September 12-20, 1997

***$1,099* First Class Hotels**

Per person, double occupancy. (Plus government taxes.)

We invite you to experience the splendor of the Swiss Alps and a chance to sample the famous "Black Forest gateau!"

Optional Tours: Lucerne, Berne, Liechtenstein; Lake Constance; Zurich; Strasbourg; Freiburg and much more!



THE HIGHLIGHTS OF ITALY AND THE FRENCH RIVIERA

September 20-28, 1997

***$1,069* First Class Hotels**

***$1,119* Superior First Class Hotels**

Per person, double occupancy. (Plus government taxes.)

Chianciano Terme - A picturesque spa town situated between Florence and Rome.

Cannes - A city of glamour and movie stars.

Optional Tours: Rome, Florence; Siena, Pisa; Genoa; Monte Carlo, Nice, St. Paul de Vence and Grasse, and more!

Available to Members, Their Families and Friends.

For additional information and a color brochure contact:

GLOBAL HOLIDAYS
9725 Garfield Avenue South
Minneapolis, MN 55420-4240
(612) 948-8322
Toll Free: **1-800-842-9023**

INCLUDED FEATURES: Round trip transatlantic air transportation, seven nights accommodations, continental breakfast daily, all airline and hotel taxes, experienced escort guides and more!

arrangements will likely continue to be ad hoc. Given the report's concerns with provider insolvency and the Commerce Department's focus on a risk adjustment system, the likelihood that a direct contracting arrangement will be subject to regulation may depend, in part, on the employer's size and whether the risk-sharing arrangement includes a mechanism that protects providers against higher-risk and special-needs populations.

What is certain in Minnesota is that the regulation of direct contracting arrangements is still evolving. Providers wishing to assume risk in connection with direct contracts should carefully consider the amount of risk assumed. Moreover, whether such arrangements can avoid regulation as insurance probably will depend, at least in part, on protecting against provider insolvency and addressing other consumer protection concerns. MM

Margo Struthers and Paul Anderson are attorneys with Oppenheimer Wolff & Donnelly and members of the firm's Health Law Practice Group. *The preceding article is a general discussion of legal issues and is not intended as legal advice. This article is no substitute for the advice of competent legal counsel who has reviewed the specific facts and law regarding any given legal matter.*

REFERENCES

1. Physicians' Defense Company v. O'Brien, 111 N.W. 396 (Minn. 1907).
2. Commissioner, Minnesota Department of Commerce, letter to the Buyers Health Care Action Group, October 8, 1996.
3. Minnesota Department Health letter to Community-University Health Care Center, July 29, 1996.
4. The McCarran-Ferguson Act, 15 U.S.C. § 1012.
5. Minnesota Statutes, Section 60A.02, Subd. 3(a).
6. Physicians' Defense Company, 111 N.W. 396 (Minn. 1907); Minn. Op. Atty. Gen., 249-B-9, December 13, 1932; May 15, 1987, letter from the Commerce Department Commissioner to Physicians Health Plan of Minnesota (regarding hospital risk contracts); Department of Commerce and Department of Health Bulletin 94-3, September 26, 1994.
7. Minnesota Statutes, Chapter 62R, the Minnesota Health Care Cooperative Act.

People and Places Making Medical News

People

New Dean at 'U' Medical School

Alfred Michael, M.D., University of Minnesota Regents' Professor and chair of the Pediatrics Department, has been named dean of the Medical School. An international leader in research and treatment of kidney diseases, Michael has been interim dean since June 1996. He replaces **Frank Cerra, M.D.,** who became provost of the university's Academic Health Center in April 1996.

St. Paul-Ramsey Chief of Professional Services

Thomas Rolewicz, M.D., Ph.D., was appointed chief of professional services for all ambulatory clinics at St. Paul-Ramsey Medical Center. In this new position, Rolewicz will provide operational and financial management to clinic and professional staff.

Before rejoining St. Paul-Ramsey in 1993, Rolewicz worked in clinical pharmacology at the University of Minnesota and as a pediatrician at St. Paul-Ramsey and Hennepin County medical centers.

New National Marrow Donor Program Board Chair

John A. Hansen, M.D., has been named board chair of the National Marrow Donor Program (NMDP). He currently heads the Human Immunogenetics Program at the Fred Hutchinson Cancer Research Center in Seattle and is a professor of medicine at the University of Washington. A Minnesota native, Hansen has served on the board since 1988 and, before that, on the board of the United Network for Organ Sharing.

The NMDP maintains a centralized computer registry to facilitate donor matching and establishes standards for donor recruitment.

New Roles for BCBSM Executives

Blue Cross and Blue Shield of Minnesota announced a realignment plan affecting top executives. **Mark Banks,** group vice president and president and CEO of Blue Plus, will also be responsible for regional and national business units marketing. Membership, claims, customer service operations, and information services will be consolidated under **Mark Durishan,** senior vice president and chief financial officer.

Andy Czajkowski, president and CEO, also announced that a search is underway for a new chief marketing officer.

St. Paul-Ramsey Executive VP of Medical Affairs

The St. Paul-Ramsey board of directors appointed **Susan L. Freeman, M.D.,** executive vice president of medical affairs. Freeman will represent the hospital and assist the medical staff and hospital management in fulfilling their obligations to each other and to their patients for quality care.

Freeman is chief of the endocrinology and metabolism section for HealthPartners and St. Paul-Ramsey Medical Center. She will retain this role and continue to see patients part time.

HSM Research, Education Institute Board Chair

The Institute for Research and Education HealthSystem Minnesota has elected **James L. Craig, M.D.,** chair of its board of directors. Craig is vice president and director of health and human services at General Mills, Inc.

Elected to three-year terms were **Frank Cerra, M.D.,** University of Minnesota Academic Health Center provost; **Jean Forster, Ph.D.,** associate professor of epidemiology, University of Minnesota School of Public Health; **Donald M. Meisel, Ph.D., D.D.,** retired pastor of Westminster Presbyterian Church in Minneapolis; and **Kathleen Ogle, M.D.,** medical director of the Cancer Program HealthSystem Minnesota.

Places

Clinics Form Partners in Pediatrics

Oakdale Pediatric & Adolescent Consultants Ltd. and Pediatric Associates Ltd. merged April 1 to form Partners in Pediatrics Ltd.: Health Care for Children and Adolescents. The merger creates more health care options for patients, while allowing parents to keep their children's current pediatric provider.

Pediatric Associates has offices in Uptown and Brooklyn Center; Oakdale Pediatric & Adolescent Consultants has offices in Robbinsdale, Maple Grove, Brooklyn Park, and Plymouth. After the Brooklyn Center office closes, physicians from Pediatric Associates will see patients at all sites, including the Uptown office. Partners in Pediatrics also offers extended evening and weekend hours at the Maple Grove location.

Patients will be hospitalized at North Memorial Medical Center and at Children's Heath Care–Minneapolis. Newborns will be seen at North Memorial, Abbott Northwestern Hospital, and Fairview Southdale Hospital.

Western Wisconsin Clinics Merge

Three western Wisconsin medical clinics with six different locations merged to form Western Wisconsin Medical Associates, S.C. The merger will allow Hudson Physicians, Inc., River Falls Medical Clinic, and New Richmond Clinic—all primary care clinics—to

expand services and make available a broader range of health care plans.

Violence Coalition Receives National Funding

A national anti-violence group announced $3 million in grants to establish violence prevention projects in 11 cities across the country, including Minneapolis. The National Funding Collaborative on Violence Prevention awarded $245,000 to Alternative to Violence Coalition, a local group that has spent the last year building public-private partnerships to implement new projects.

The Perfect Fit...

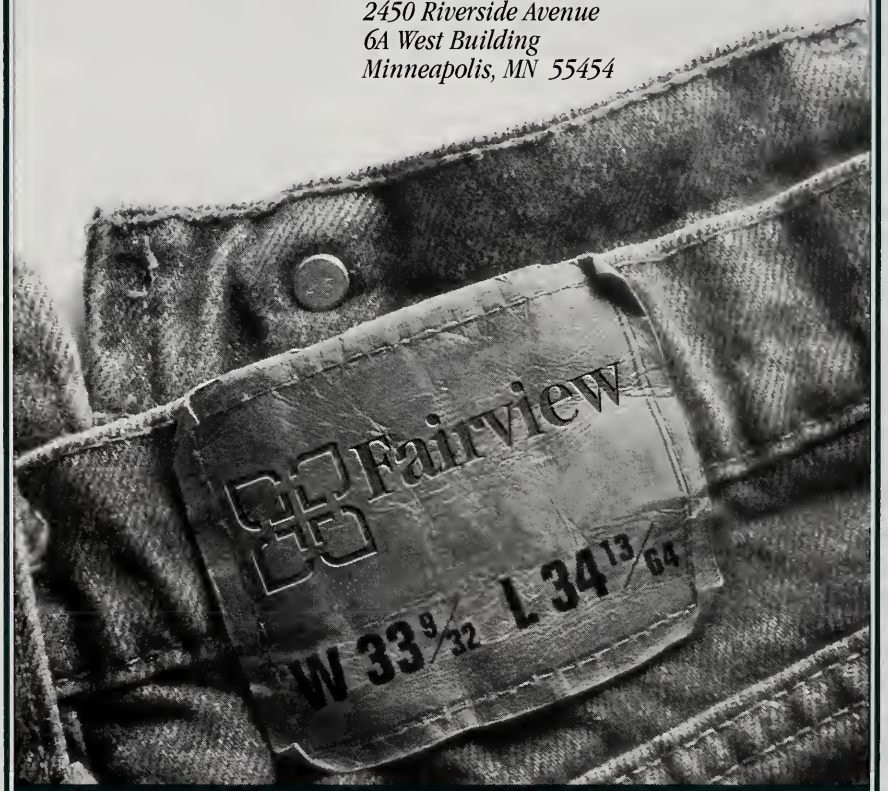
...is a rare find. Fairview Health System represents a wide spectrum of practice and lifestyle options in Minnesota. We will help you locate opportunities that are tailored to fit your needs in communities that match your size.

Opportunities now available in communities large, medium and small (and sizes in between) for...

- **Endocrinology**
- **Family Practice**
- **General Surgery**
- **Internal Medicine**
- **Obstetrics/Gynecology**
- **Orthopedic Surgery**
- **Urgent Care**
- **Urology**

Fairview

Physician Recruitment & Retention Dept.
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454



612-672-2288 or 1-800-842-6469 • E-mail: fhsrecruit@aol.com

Socioeconomics

Minnesota Hospitals Rank High in Cost Efficiency

Minnesota's hospitals are the third most cost-efficient in the nation, after North Dakota and Nebraska, according to a study published in the March 13 *New England Journal of Medicine*. The primary reason for lower administrative costs in Minnesota is that most hospitals in the state are non-profit, said study co-author **David Himmelstein, M.D.** In 1994, administration accounted for 21.1 percent of Minnesota hospital costs, compared with 34 percent for for-profit hospitals nationwide.

"If administrative costs in Minnesota's hospitals were equivalent to those in for-profit hospitals, total hospital administrative costs in Minnesota would have been $466 million higher in 1994," said St. Paul physician **Glenn Pearson, M.D.**, in a Twin Cities-based *Star Tribune* article. Pearson is president of the Physicians for a National Health Program.

The study is based on an analysis of Medicare data filed by more than 5,000 hospitals, including 156 in Minnesota.

An editorial accompanying the report questioned whether administrative costs reflect overall efficiency. A spokesperson for the Federation of American Health Systems, which represents for-profit hospitals, said the study wrongly interpreted government data and contradicted other federal statistics.

Panel Named to Draft Health Care Bill of Rights

President Clinton named a bipartisan panel to draft a bill of rights that would protect patients in the changing health care field. The panel's efforts are in response to public and physician concern over

a perceived decline in the quality of care as private managed care firms gain control of a market once dominated by independent physicians.

Sheila Leatherman, executive vice president of United HealthCare Corp., was the only Minnesotan named to the commission. She said that a lot of attention has been focused on containing costs and not enough on quality of care. The commission plans to hold hearings and use databases to examine whether quality of care is suffering.

1996 Health Plan Enrollment Up

More than 50 percent of Minnesotans are enrolled in network health plans, according to a Minnesota Council of Health Plans' summary of heath plan financial reports. Health plan enrollment in Minnesota increased for the eighth consecutive year to more than 2.2 million members—more than 12 percent above 1995. These figures include both insured and self-funded enrollment.

The area of fastest growth was among small health plans (those serving fewer than 60,000 members). Enrollment in these plans grew by more than 28 percent, compared with an 11.5 percent increase among larger health plans. The small group market, representing businesses with two to 49 employees, also experienced growth. More than 212,000 of the plans' members are from small groups, up 41 percent from 1995.

Lean Financial Year for State Health Plans

Minnesota health plans in 1996 had their leanest financial year since 1988, according to data released by the Minnesota Council of Health Plans. Seven of the nine health plans reported losses, indicating they are being squeezed by higher medical costs and the competitive pressure to keep premium increases down.

Many health plan executives anticipate an increase in premiums charged to employers and consumers. "Higher costs always mean higher premiums," said **George Halvorson,** chief executive of HealthPartners, in a Minneapolis-based *Star Tribune* article. "The cost of care has been going up while premiums have remained flat, and that can't continue."

Psychiatrist Divorce Rate Higher Than Other Doctors'

While the divorce rate for psychiatrists is on par with Americans in general, it is almost three times higher than the rate for internists, according to a study of 1,248 doctors who graduated from the Johns Hopkins University School



For the past 100 years, we've been creating new stories every day about our care for kids with chronic conditions.

Kimberly's Story

At age 6, Kimberly wasn't able to sit upright when she came to Gillette Children's for treatment for her cerebral palsy.

But with the advanced technology at Gillette Children's, with therapy at the hospital and at home, and through sheer determination, Kimberly learned to walk.

Her adoptive mother says Kimberly, now 11, has stepped into a new world of independence.

Since 1897...

Gillette Children's
Specialty Healthcare

An Essential Community Provider

For more information or a referral, call (612) 229-3851

- Cerebral Palsy and other neuromotor delays
- Spina bifida
- Juvenile arthritis
- Brain and spinal cord injuries
- Epilepsy
- Complex orthopaedic conditions
- Chronic pain
- Technology dependency

"Although we live in the country, work is just a short bike ride away... that's unique."
Donald R. Paugh, M.D.



WASHINGTON

The Wenatchee Valley Clinic, a prominent 140+ physician, multi-specialty group practice in the Pacific Northwest has several practice opportunities throughout its practice locations. **Currently, we are seeking:**

WENATCHEE

- **Neurosurgeon**
- **Cardiologist**
- **Infectious Disease**

OMAK/MOSES LAKE

- **Family Practice w/OB**
- **Obstetrician**
- **Ophthalmologist**
- **Urgent Care**
- **Dermatologist**
- **General Internist**
- **Gastroenterologist**

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Please send CV to James Brown, M.D. -

P.O. Box 489
Wenatchee, WA 98807
FAX (509) 664-7178

Wenatchee Valley Clinic

Family Practice Residency Faculty

La Crosse-Mayo (formerly St. Francis-Mayo) Family Practice Residency seeks a sixth full-time physician for the position of Assistant/Associate Director. We are expanding to add three Rural Training Track programs. The La Crosse-Mayo program has a 21-year history of training family physicians and is one of the premiere programs in the upper Midwest. Applicants must be American Board of Family Practice certified and experience in teaching is a plus. Extremely competitive salary and benefit package. Send CV to Thomas J. Grau, MD, Program Director, La Crosse-Mayo Family Practice Residency, 700 West Avenue South, La Crosse, WI 54601 or call Physician Services at 1-800-269-1986.

of Medicine from 1944 to 1960.

Psychiatrists, at 50 percent, and surgeons, including obstetricians and gynecologists, at 33 percent, had the highest divorce rates. For other specialties, the divorce rates were 24 percent for internal medicine, 22 percent for pathology and pediatrics, and 31 percent for "others," including public health, radiology, and rehabilitation medicine. The divorce rate for the U.S. population in general was 50 percent in 1995.

Death Rates Higher for Those Who Smoke After Angioplasty

Smokers who continue to smoke after undergoing angioplasty double their risk of dying from a heart attack, Mayo Clinic researchers reported in the March 13 *New England Journal of Medicine*.

"The smokers continue to develop coronary problems after revascularization," said **David Holmes Jr., M.D.**, director of Mayo's adult coronary catheterization laboratory, in a Twin Cities-based *Star Tribune* article. Smokers in the study were 76 percent more likely than nonsmokers to die of any cause and nearly twice as likely to die of heart attacks during the follow-up period after angioplasty, based on age-adjusted calculations for smokers and nonsmokers.

Minnesota No. 1 in Providing Kids' Health Care

Minnesota has the lowest percentage of uninsured children, a survey of all states revealed. About 22 percent of the state's children have no health insurance, compared with the national average of one-third. Most of the uninsured children—defined as those going without insurance for at least one month during the year—live in working families, according to the report by the Families USA organization.

Law & Policy

Nurse Anesthetists File $1 Billion Suit

The Minnesota Association of Nurse Anesthetists (MANA) leveled charges against Allina Health System, several state hospitals, and about 50 anesthesiologists, accusing them of more than 100,000 instances of Medicare fraud. According to a March 25 St. Paul *Pioneer Press* article, the MANA complaint includes hundreds of examples of alleged fraudulent billing—primarily cases where anesthesiologists were not in the operating room during the time anesthesia was being administered.

Tobacco Firm's Deal Doesn't Satisfy Blue Cross

An agreement the Liggett Group has made with 22 state attorneys general to drop charges against the cigarette maker "promises much but delivers little," said **Andy Czajkowski**, Blue Cross and Blue Shield of Minnesota president and chief executive, who refuses to drop litigation.

Attorney General Hubert Humphrey III, who has teamed up with BCBSM to sue cigarette makers, supported the settlement, which requires Liggett to acknowledge the perils of smoking and hand over evidence that might help lawyers win verdicts against other tobacco companies. In return, Liggett would be dropped from the attorney general's lawsuit and its chief executive would become a cooperating witness. Liggett also would pay 25 percent of its profits into a settlement fund.

Tom Gilde, associate corporate counsel for BCBSM, said that a side agreement, negotiated with the attorney generals' deal, attempts to force nongovernmental litigants to settle claims against Liggett. Gilde called the agreement unconstitutional. Humphrey said that the law firm that represents the state and BCBSM in the case will challenge the Liggett side agreement.

Medical Research

Southeast Asian Babies Healthy Despite Lack of Prenatal Care

Low rates of infant mortality among Southeast Asians in the Twin Cities have been attributed to strong traditions of self-care, family, and community support, according to research coordinated by the Urban Coalition of St. Paul. These findings are despite a high rate of poverty and a low number of Southeast Asian women receiving adequate prenatal care.

Between 1989 and 1993, the infant mortality rate for Southeast Asians was 5.4 per thousand, compared with 7.1 statewide. Researchers have long known that Southeast Asian pregnancies have better outcomes than other groups, according to **Norbert Hirschhorn, M.D.**, director of the division of family health for the Minnesota Department of Health. "Not very many Southeast Asian women smoke or use alcohol," he said in a *St. Paul Pioneer Press* article. "They're doing things we'd like a lot of people to do."

Interviewed for the survey were 116 Hmong, Laotian, Cambodian, and Vietnamese mothers of newborns. The mothers identified as barriers to prenatal care cost of care, arranging transportation and child care, and language difficulties.

Innovations

Lymphatic Mapping Could Improve Breast Cancer Surgery

A procedure adopted by cancer surgeons at Park Nicollet Clinic HealthSystem Minnesota and the University of Minnesota to treat melanoma will be used, on an experimental basis, to treat breast cancer as well. Trials began in April.

Called lymphatic mapping, the procedure could decrease significantly the number of breast cancer patients who wait weeks or months to find out whether their cancer has spread. The procedure uses a two-step approach. On the day of surgery, the cancerous lesion is injected with a radioactive tracer and a blue dye. "These agents behave like cancer cells," said **Todd Tuttle, M.D.**, a surgical oncologist at Park Nicollet who brought the technique to the Twin Cities from the University of Texas M.D. Anderson Cancer Center in Houston. The cancer-like agents travel through the lymphatic system, and the first lymph node they encounter is the so-called sentinel node. From there, they may spread to other lymph nodes in that region.

Surgeons then administer a local anesthetic. Working outside the body, they use a probe that detects concentrations of radioactivity to locate the sentinel node. They make an incision and remove the node, which is examined by the pathology lab. If the sentinel node contains no tumor cells, the other lymph nodes in the area are likely to be healthy as well.

Brain Stimulator Successfully Treats Parkinson's

University of Minnesota surgeons successfully implanted a battery-powered stimulator into the brain of a man who had uncontrollable tremors, erratic movements, and painful muscle cramps associated with Parkinson's disease. The procedure was the first of its kind in Minnesota and only the third in the nation.

The patient, Bob Zgonc, from Chisholm, has been completely relieved of his debilitating symptoms nearly six months after the procedure. **Robert Maxwell, M.D.**, professor and head of neurosurgery, placed a threadlike fiber containing four electrodes into the pallidum area of Zgonc's brain. The electrodes connect to a two-inch battery that was implanted beneath the skin in Zgonc's chest, much like a pacemaker. The battery powers the electrodes to stimulate the brain at high frequencies, controlling the hyperactive

First Call Physicians, Inc.
A Locum Tenens Service
500 Eighth Ave. S.
Buffalo, MN 55313

Clinics/Hospital | **Physicians**

Locums Coverage
=
Revenue

- Patients falling through the gaps?
- Physician burnout or illness?
- Shortage of physicians?

- Earn more with less time.
- No administrative headaches.
- Malpractice premium paid.

Experience, Service, Honesty
Call (metro) 682-3852
(toll free) 888-682-3852

(You'll be glad you did!)

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Internal Medicine
Occupational Health
Ob/Gyn

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES

LICENSED LOCUM TENENS PHYSICIANS

Are you in need of a physician or specialist to cover for a vacation, seminar, or just need extra help? Or are you looking for a part-time, hassle free position for some extra money?



Whitesell
Medical Locums, Ltd.

Whitesell Medical Locums, Ltd.
Eight First Avenue South
Buffalo, MN 55313
Phone: 800-876-7171
or 800-295-6373
Fax: 682-4791



"Commuting has been eliminated and we've gained sunshine and a more relaxed pace of life." David J. Houghland, M.D

GASTROENTEROLOGIST

WASHINGTON - A unique opportunity now exists for a well-trained GI who has skills in therapeutic endoscopy. This new practice at our 19 provider multispecialty clinic in Moses Lake, Washington, has been developed as an outreach program from our central 140 physician group clinic in Wenatchee. Demand for services has reached the point to warrant a fulltime resident gastroenterologist.

The position entails full time GI and sharing endoscopy call with a general surgeon in this lake front community. The clinic has a recently completed ambulatory surgery and endoscopy center with video endoscopy. Samaritan Hospital, a 50 bed acute care hospital with well equipped ICU and endoscopy units, as well as a 24-hour staffed emergency department, is located less than a mile away.

Moses Lake, on the shores of a large recreational lake of the same name, is located in central Washington. The community, recently ranked among the top 100 smaller communities in the U.S., has a population of 15,000 with 60,000 in close proximity. The prospect for growth is excellent in part due to a desirable location with one of the largest airports in the state (site of a major airline pilot training facility) and convenient interstate highway access.

Abundant recreational opportunities exist on and around the lake as well as alpine skiing 65 miles away.

Please send CV to James Brown, M.D. -
P.O. Box 489
Wenatchee, WA 98807
FAX (509) 664-7178

Wenatchee Valley Clinic

nerve cells that cause movement disorders.

Maxwell and Walter Low, M.D., professor of neurosurgery, are co-prinicipal investigators of the univerisity's pallidal stimulation study, for which Zgonc is the first subject.

The University of Minnesota and the University of Kansas are the only institutions approved by the Food and Drug Administration to perform pallidal stimulation.

An FDA advisory committee recently recommended approval for widespread use of thalmic stimulators, a similar device that controls only tremors. MM

Health Volunteers Overseas

D·I·S·C·O·V·E·R

THE WORLD

Health Volunteers Overseas is dedicated to improving the availability and quality of health care in developing countries through training and education.

Volunteer your skills! Become a member of Health Volunteers Overseas!

For more information, call 202-296-0928

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

MAY 1997

May 6-9 **Fourth International Surgical Pathology Symposium** Mayo Medical Laboratories; Hotel Estoril Sol, Cascais, Portugal. CONTACT: Kathy Bates, Mayo Medical Laboratories, Office of Continuing Education, 200 First Street SW, Rochester, MN 55905; 800/533-1710.

May 11 **Preventive Medicine** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 12-14 **Mayo Clinic Nicotine Dependence Seminar: Counselor Training and Program Development** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

May 16 **John I. Coe Symposium** Hennepin County Medical Center; St. Cloud Civic Center, St. Cloud, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

May 17 **Retinal Update: Laser Photocoagulation of Retinal Diseases** Phillips Eye Institute; Minneapolis, MN. CONTACT: Leslie Gibson, Phillips Eye Institute, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061; fax 612/870-0315; E-mail gibson@allina.com

May 20 **Diagnosing Breast Cancer: A Team Approach to Early Detection** Minnesota Medical Association and Midwest Medical Insurance Company; Airport Marriott, Minneapolis, MN. CONTACT: Robin Houlihan, Midwest Medical Insurance Company, 6600 France Avenue S, Suite 245, Minneapolis, MN 55435; 612/922-5445 or 800/328-5532.

May 20-21 **Advances in Inherited Urea-Cycle** University of Minnesota Continuing Medical Education; Hotel Schloss Wilhelminenberg, Vienna, Austria. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 21-23 **Current Concepts in Radiation Therapy** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

May 24-29 **American Academy of Physician Assistants' 25th Annual Conference** American Academy of Physician Assistants; Minneapolis Convention Center, Minneapolis, MN. CONTACT: Sharon Kirksey, American Academy of Physician Assistants, 950 North Washington Street, Alexandria, VA 22314-1552; 703/684-1924 ext. 3405.

May 29-June 1 **Workshops in Clinical Hypnosis: Introductory and Advanced** University of Minnesota Continuing Medical Education; Sheraton Inn–Midway, St. Paul, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JUNE 1997

June 6-7 **Optimizing Disease Management Through Pulmonary and Gas Exchange Diagnostics** University of Minnesota Continuing Medical Education; Marquette Hotel, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 7 **Acute Care for the 21st Century: A Team Approach** Mayo Clinic/Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Leanne Andreasen, Meeting Planner, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

June 11-14 **Fiftieth Anniversary Mayo Interventional Cardiology Symposium** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

June 18-20 **Topics and Advances in Pediatrics** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 18-21 **Annual Surgery Course: Advances in GI and Laparoscopic Surgery** University of Minnesota Continuing Medical Education; Willey Hall and Marriott City Center Hotel, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Family Practice Variety

HealthPartners has a variety of opportunities for BC/BE family practitioners. These are primarily adult practices, some full range and some limited range, most in ambulatory settings. Urban or suburban practices are available.

HealthPartners Bloomington Clinic
Large suburban clinic located in Bloomington, just south of Minneapolis.

HealthPartners Riverside Clinic
Just outside of downtown Minneapolis, this clinic serves a widely diverse population.

HealthPartners Skyway Clinic
Downtown Minneapolis clinic practice involving no OB and limited peds.

HealthPartners Woodbury Clinic
Our newest clinic, located in the fastest growing suburb of St. Paul. Full range practice.

Ramsey Clinic Maplewood
Suburban location with a full range practice including peds with OB optional.

For more details on specific openings and clinic sites, contact Lori Fake at (612) 883-5337 or (800) 472-4695. For consideration, forward your CV to: HealthPartners, Physicians Services, P. O. Box 1309, Minneapolis, MN 55440-1309. EO/AA Employer.

HealthPartners

HealthPartners' mission is to improve the health of our members and our community



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 32-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- PEDIATRICS
- INTERNAL MEDICINE/PULMONOLOGY

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

June 18-21 **Sixty-first Annual Course: Advances in Gastrointestinal and GI Laparoscopic Surgery** University of Minnesota Department of Surgery, University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JULY 1997

Jul. 13-19 **Mayo Clinic Internal Medicine Board Review 1997** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jul. 14 **Diagnosing Breast Cancer: A Team Approach to Early Detection** Minnesota Medical Association and Midwest Medical Insurance Company; St. Luke's Hospital, Duluth, MN. CONTACT: Robin Houlihan, Midwest Medical Insurance Company, 6600 France Avenue S, Suite 245, Minneapolis, MN 55435; 612/922-5445 or 800/328-5532.

Jul. 20-22 **Update in Otolaryngology: Head and Neck Surgery** Mayo Foundation; Skamania Lodge, Stevenson, WA. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jul. 24-26 **Management Strategies in Hematology** Mayo Medical Laboratories; Whistler, British Columbia. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 507/284-8599.

Jul. 29-31 **Third Annual Mayo Multidisciplinary Symposium on Platelets, Blood Vessels, Biomaterials, and Transfusion** Mayo Foundation; Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jul. 31-Aug. 2 **Bleeding and Thrombosing Diseases: Back to the Basics** Mayo Medical Laboratories; Rochester, MN. CONTACT: Mayo Medical Laboratories, Office of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/533-1710 or 507/266-4373, or fax to 507/284-4542.

AUGUST 1997

Aug. 9 **Advanced Phacoemulsification Techniques** Phillips Eye Institute; Minneapolis, MN. CONTACT: Leslie Gibson, Phillips Eye Institute, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061; fax 612/870-0315; E-mail gibson@allina.com

Aug. 10-12 **Success with Failure: Evaluation and Treatment of Congestive Heart Failure** Mayo Foundation; Vail Cascade Hotel and Club, Vail, CO. CONTACT: Registrars, Mayo Foundation, Office of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., May 15 for July ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

Olmsted Medical Center is seeking BC/BE physicians in family medicine. Great opportunity for well-trained physicians to join a 75-physician multispecialty group in a dynamic, progressive practice. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes 10 branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (*5/96-R)

Rent Our Caribbean-Shore Home—Silver Sands, Jamaica. Cook, maid, your own pool. Sleeps eight. Great for families, groups. Rent from $1,995/week winter, $1,395 off-season. 800/260-1120. (10/96-R)

Fergus Falls Medical Group is expanding its 33-physician multispecialty clinic and is seeking physicians in the following specialties: dermatology, family practice, urology, and ob/gyn. Excellent salary/benefits package. For confidential information on this opportunity, contact David T. Bjork, M.D., or Jim Wilkus, Administrator, 615 South Mill Street, Fergus Falls, MN 56537; 800/247-1066. (1/97-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice-trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Physician Needed to work part time in multidisciplinary clinic. All calls confidential to doctor's private line, 612/889-5973. (6/96-R)

Part-time Neurologist wanted for multidisciplinary office, no call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Urgent Care Physicians: We are a growing urgent care practice looking for BC/BE physicians to work full- or part-time to staff our four clinics. We currently have three locations in the metro area and one location in Mankato and are planning on expanding in 1997. Please contact Cara Auge at 612/593-9818 or 800/511-2820 for more information on joining our growing practice, or send inquiries to 9800 Shelard Parkway, #210, Plymouth, MN 55441. (4/97-R)

Manitowoc, Wisconsin: The Manitowoc Clinic, a member of the Aurora Health Care system, is seeking a general internist to join our 16-physician multispecialty group. Guaranteed two-year salary and excellent benefits package. Contact, or send CV to, James Robinson, Administrator, Box 1270, Manitowoc, WI 54221-1270. Telephone 414/682-8841. 3-7/97

Join a medical group rich in support in an area rich in natural beauty.

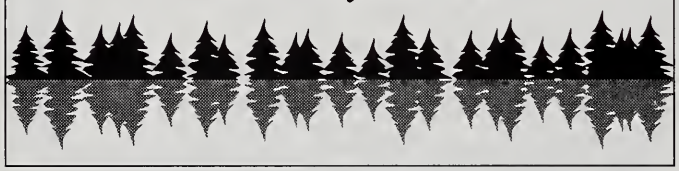
Duluth Clinic, a 300-physician multispecialty group, with 22 regional centers, and serving a regional referral population of 460,000, seeks to add physicians in the following areas:

EP Cardiology	**Neurology**
Dermatology	**Neurosurgery**
Emergency Medicine	**Orthopedic Surgery**
Family Practice	**Pediatrics**
Internal Medicine	**Psychiatry**
Nephrology	**Radiology**

We offer professional autonomy combined with excellent fringe benefits and generous vacation/CME time. If a quality lifestyle is important, this is your opportunity.

Please contact Mike Griffin or Marci Jackson, SMDC, 400 E. 3rd St., #40, Duluth, MN 55805 or call 1-800-342-1388 or fax 218-722-9952
or e-mail to: sr@smdc.org

SMDC
St. Mary's/Duluth Clinic Health System *eoe*



Urgent Care Physicians: Opportunities for BC/BE family practitioners. St. Francis Medical Center in Shakopee, 30 minutes southwest of Minneapolis, is opening an urgent care at the hospital in May 1997. Evening and weekend hours are available for permanent positions or moonlighting. A second location in Chaska, 10 minutes northwest of Shakopee, is opening August 1997. Paid malpractice. Contact Debbie Modder, Allina Health System, Route 81465, 5601 Smetana Drive, Minnetonka, MN 55343; 612/992-3094 or 800/248-4921. 4-7/97

Practice to Take Over: Well-established internal medicine practice in downtown Minneapolis. Large patient base. Well-equipped for internal medicine. COLA certified laboratory. In-office computerized billing system. Nominal charge for equipment and goodwill. The incoming physician is expected to be busy from day one. Ideal for new residency graduate who has an ambition to be independent or to start own group. Will introduce. Forward all inquiries to: Minnesota Medical Association, Box 864, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. 4-7/97

University of Minnesota–Dentistry Faculty: University of Minnesota School of Dentistry invites applicants through 6/30/97 for part-time, non-regular faculty for consultative diagnostic and treatment planning services in specialty clinics. Medical degree is required with training and experience in otolaryngology or reconstructive surgery cleft

FAMILY PRACTITIONERS: ARE YOU LOOKING FOR...

A CHALLENGING CLINICAL PRACTICE?

- Join 3 F.P. and 2 N.P. in a clinic with 25,000 annual patient visits
- Financially stable 31-bed hospital, 74-bed LTC, and HH agency
- Access to 26 outreach specialists
- Including Operative, Obstetric and Emergency Services

A GOOD LIFE?

- Working flexible 4.5 day week with 1:4 weekend and night call
- A progressively diverse rural community
- Within two hours of Fargo and Sioux Falls and three hours of Twin Cities
- Recreation: Big Stone Lake, 18-hole golf course, National Wildlife Refuge

A SUPPORTIVE COMMUNITY?

- Community-based Health Care Foundation with $1 million dollars pledged
- Providing competitive package including:
  - Guaranteed starting salary w/incentive
  - Two year housing allowance
  - Educational loan repayments



C.V. in confidence to Fred Peterson, Admin.,
Ortonville Area Health Services,
Ortonville, MN 56278.
Phone: (320)839-2502; FAX: (320)839-2507. EOE.

South Dakota
Room to Grow

Just imagine...the luxury of outdoor life in a traditional practice in Mitchell, South Dakota. The clinic is seeking a fifth BC/BE FP with OB. Quality family life, low crime rate...and **No State Income Tax!** Above national average compensation and comprehensive benefit package. Call today! Or send your CV to Pam Martin, Business Manager, Mitchell Clinic, 818 W. Havens, Mitchell, SD, 57301. 1-605-996-7772



palate patient care. Faculty rank dependent upon experience and training. Send résumé (indicating specialty or area[s] of clinical expertise) to Dean's Office, University of Minnesota School of Dentistry, 15-209 Moos Tower, 515 Delaware Street SE, Minneapolis, MN 55455. The University of Minnesota is an equal opportunity educator and employer. 1-5/97

Olmsted Medical Center: A 75-physician multispecialty group practice is searching for qualified physicians to complement the emergency medicine staff (variety of shifts available). Our Level II emergency department has an annual volume of 18,000 patients and advanced technology to provide the highest quality care. Excellent salary and malpractice insurance coverage provided. Contact: Lois Till-Tarara, Olmsted Medical Center, 1650 4th Street SE, Rochester, MN 55904; 507/287-2430. *3-7/97

Luther Midelfort–Mayo Health System: A thriving 160-physician multispecialty clinic and hospital in Eau Claire, Wisconsin, is seeking two BC/BE general internists. Positions are open in the Eau Claire and Chippewa Falls offices. Call of 1:6, competitive compensation and benefits package, and a stable work environment are only a few of the benefits of these positions. Eau Claire is a university community of 60,000 people, 90 minutes east of Minneapolis/St. Paul. Contact Christie Blink at 800/573-2580, or fax 715/838-6688. *3-7/97

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 25 member medical staff has openings in the areas of:

Family Medicine — **General Surgery**
Orthopedic Surgery — **Psychiatry**
OB/GYN — **Podiatry**

CHISAGO HEALTH SERVICES
A subsidiary of Fairview

Please contact:
Physician Recruitment and Retention Department
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454
1-800-842-6469

Suburban Family Practice Opportunity

Our HealthPartners' Bloomington Clinic offers family practitioners the opportunity to practice primarily adult medicine in a team oriented atmosphere. We currently have a full time opening combining trauma, orthopedics and sports medicine in an ambulatory setting.

To learn more, contact Lori Fake at (612) 883-5337, (800) 472-4695 or via e-mail: lori.m.fake@healthpartners.com. For consideration, forward your CV to: HealthPartners, Physician Services, P.O. Box 1309, Minneapolis, MN 55440. EO/AA Employer

HealthPartners

HealthPartners' mission is to improve the health of our members and our community

Neurologist, Oncologist, Urgent Care

There are immediate openings at Brainerd Medical Center for a Neurologist, an Oncologist, and an Urgent Care physician.

Brainerd Medical Center, P.A.
- 35-Physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162 bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota
- Surrounded by the premier lakes of Minnesota
- Located in central Minnesota less than 2 ½ hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:
- Curt Nielson
  (218) 828-7105
  or (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

Luxurious geodesic home on secluded trout stream in Black Hills National Forest, South Dakota. Sleeps 10-12. Fully equipped kitchen, $700 a week. Call 320/274-5219 or 320/274-5113. 2-5/97

Luther Midelfort–Mayo Health System: A thriving 160-physician multispecialty clinic and hospital in Eau Claire, Wisconsin is seeking a BC/BE family practitioner for our Chetek, Wisconsin office. A desire to practice ob/gyn is essential. General call of 1:10 and ob/gyn call of 1:7 is expected. Physicians do not have first call in the ER. A newly remodeled office will be shared with one other family practitioner. Chetek, located 40 miles north of Eau Claire, is in the heart of resort country. Located on a chain of six connecting lakes, Chetek offers four-season recreation for the outdoor enthusiast. For further information, contact Christie Blink, Physician Recruitment Coordinator at 800/573-2580, or fax 715/838-6688.

*3-7/97

MAY 1997 INDEX TO ADVERTISERS

Air Force Health Professionals–Ft. Snelling 11
Alexandria Clinic, P.A. 60
Allina 5
Aspen Medical Group 51
Bearpath Golf Course ..... Cover 4
Brainerd Medical Center 63
Cascade Lodge 51
Central Minnesota Group Health Plan 30
Chisago Health Services 63
Fairview Clinic Services 54
First Call Physicians, Inc. 57
Franciscan Skemp Healthcare. 56
Gillette Children's Specialty Healthcare. 55
Global Holidays 52
HealthEast Bethesda 3
HealthPartners 7, 30, 60, 63
Hennepin Faculty Associates 17
Hudson Physicians 52
International Falls Visitor & Convention Bureau 52
Medical Protective Company ..... Cover 2
Midwest Medical Insurance Co. 21
Mitchell Clinic 62
MMBR 18, 31, 32, 47, 48
Mork Clinic, P.A. 30
Multicare Associates of the Twin Cities 57
Ortonville Area Health Services 62
St. Mary's/Duluth Clinic Health System 62
Staff Care, Inc. 7
THC Minneapolis 5
United HealthCare Corporation 17
Wenatchee Valley Clinic 56, 58
Whitesell Medical Locums, Ltd. 58

1-800-4-CANCER

Knowledge
It's Part of
the Cure

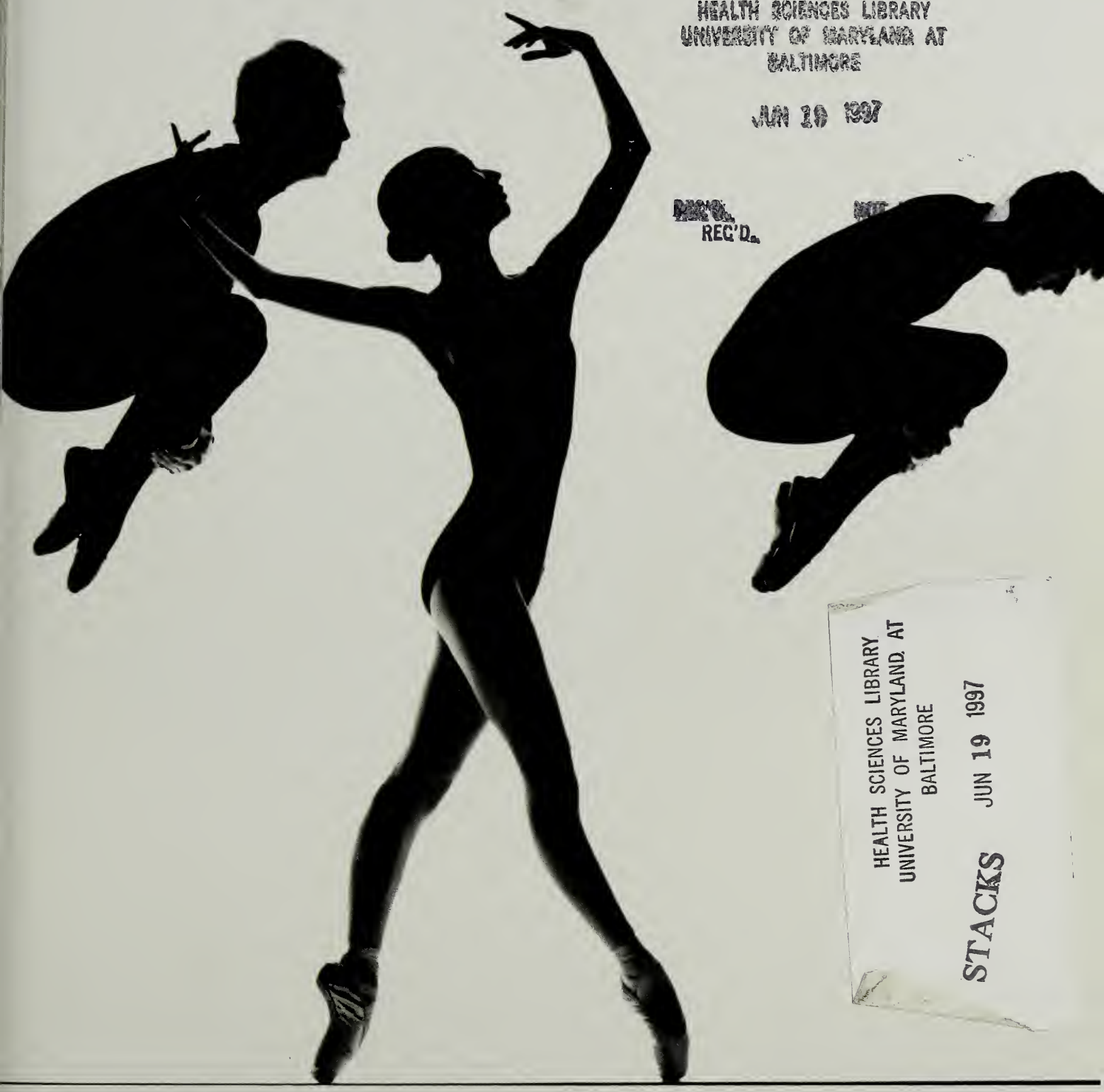
Thanks to research, we now know much more about breast cancer and how to treat it. Today, most women with breast cancer who are diagnosed and treated early continue to lead active and vibrant lives.

For current information on breast cancer, call the *National Cancer Institute's Cancer Information Service* at **1-800-4-CANCER**.

Minnesota Medicine

A JOURNAL OF CLINICAL AND HEALTH AFFAIRS

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE
JUN 19 1997
REC'D.



HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE
JUN 19 1997
STACKS

Healing Arts for Performing Artists

JUNE 1997



THE
MEDICAL PROTECTIVE COMPANY ®

Professional Protection Exclusively since 1899

To reach your local office, call 800-344-1899.

GOLD CORPORATE AFFILIATE
MGMA
FOUNDED 1926
PROGRAM UNDERWRITER

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover photograph from the James Sewell Ballet's "Moving Works," 1996, by Erik Saulitis. Above: dancer James Sewell.

DEPARTMENTS

2 ..... Editor's Notebook

24 .... Author Instructions

54 .... News Clips

60 .... CME in Minnesota

61 .... Classified Ads

64 .... Index to Advertisers

FACE TO FACE

6 **Easing Performers' Pain** ..... Kim Palmer
As director of Sister Kenny's Instrumental Artists Clinic, Jennine Speier, M.D., helps artists recover from injuries and keeps them performing at their best.

PERSPECTIVES

10 **The Road Best Traveled** ..... Robert L. Veninga, Ph.D.
Practical strategies to help physicians stay renewed in their careers.

COVER STORY

16 **Performing Arts Medicine Crescendoes con Spirito** ..... Howard Bell
Tuned in to the special needs of their artist patients, performing arts physicians work together to keep their patients in the spotlight.

CLINICAL & HEALTH AFFAIRS

25 **A Good Walk Spoiled: Golf's Links to Medicine** ..... Douglas D. Brunette, M.D., F.A.C.E.P.

PUBLIC HEALTH REPORT

41 **Shaken Baby Syndrome: Diagnosis and Prevention** ..... Jane Swenson, M.S., C.P.N.P., and Carolyn Levitt, M.D.
A thorough understanding of shaken baby syndrome can help physicians diagnose and prevent this deadly form of abuse.

SPECIAL REPORT

45 **Geographic Disparities in Medicare Reimbursement** ..... Janet Silversmith
A host of policies have been proposed to create an equitable reimbursement system.

MEDICINE LAW & POLICY

52 **Are Medical Savings Accounts an Effective Insurance Alternative?** ..... Kimberly Halva, J.D.
A recent health insurance act has stirred up discussion over the controversial MSA.

33 The Monitor

Highlights ..... *Two percent tax reduced, $400 surcharge repealed • Summary of the 1997 legislative session • MMA response to flood devastation*

No Clubs in this Closet

I have a confession to make. I'm not a real doctor. After years of masquerading, I'm "outing" myself. Oh, I did earn an M.D., and I am licensed to practice medicine in Minnesota. I'm even a board-certified internist. But, I'm not a real doctor—I don't play golf!



It's not that I haven't tried. My best friend in high school, who shot in the low 80s and lionized Arnold Palmer, seduced me onto the links one summer. By the end of that summer, having visited more tall grass and water than any gator, I made the second wisest choice of my life—the first was asking my wife to marry me—I handed in my clubs, forever.

"I was wiser than my high school years when I rejected pasture pool and guaranteed my future serenity."

Since then I have been a closet golfophobe, smugly smirking at all the frustrated golfers around me. My love of Mark Twain was cemented when I first read his description of golf, "a good walk spoiled," also the title of Dr. Douglas Brunette's clinical article in this issue (page 25). Doug, who I believe is an otherwise sane person, apparently persists in his pursuit of the little white ball, despite having read every reference to golf in the medical and quasi-medical literature documenting the overwhelmingly dangerous nature of the sport. Perhaps one of the many chapters of GA (golfers anonymous) or PA (putters anonymous) or HA (hackers anonymous) will offer Doug the help he needs to see the truth.

At the risk of raining on Doug's enjoyable article and possibly dimming the excitement of the post-Tiger Masters, here are my golf truths, gleaned from years of golf watching:

- Golf is bad for your psychological health. Have you ever met any golfers happy with their game?
- Golf is bad for marriages. Even if spouses play together, marital bliss seldom prevails on the fairway.
- Golf is bad for the economy. The billions of dollars spent on club dues and green fees, equipment, golf trips—likely greater than the GNP of most underdeveloped countries—could reduce the national debt if put to better use.
- Golf is bad for the advancement of modern civilization. The four-plus hours it takes to play 18 holes, when multiplied by millions of golfers, equates to years of wasted time that could have been devoted to solving the health care crisis or thinking about the Big Bang.

After surveying the above list, it's clear to me that I was wiser than my high school years when I rejected pasture pool and guaranteed my future serenity. Instead, I chose safe, non-addicting avocations like surfing (at the computer) and playing the trumpet. Certainly nobody would spend days and thousands on computers!

Well, at least the trumpet is safe. Or is it? Read our profile (page 6) and cover story (page 16) about performing arts medicine. Entire clinics have been established to treat performers' health problems, such as violinists' sore arms, pianists' painful fingers, and dancers' pulled tendons.

Although cold sores are the worst brass-player's ailment described in our articles on performing arts medicine, my own quick research revealed scary dangers like premature baldness, hernias, and early death in trumpet players.

So maybe there is no perfect avocation. I guess I'll keep hacking on the computer keyboard and tooting my own horn. Perhaps I should try the bagpipe or the kazoo. Or maybe I should take a walk around Hazeltine.

–Charles R. Meyer, M.D., Editor-in-Chief

Partners In Your Future



"When I began my practice, there was a malpractice crisis in the United States. MMIC was there and they were very helpful. They have always been very supportive."

Judith Shank, MD
Metropolitan Dermatology
Plymouth, MN

In today's changing medical environment, physicians need to view their professional liability insurer as an important partner in their future. And what better partner can a physician have than a physician-owned and controlled liability insurer such as Midwest Medical Insurance Company. A company that understands a physician's desire to practice the art of medicine.

As your partner, MMIC is here to assist you in your new working relationships and to develop products and programs which improve patient care and lower liability exposures.

MMIC is here for the long term. We bring to the partnership a financial strength of over $251 million in assets and a total equity of over $104 million. Our rating from A.M. Best is A (EXCELLENT).

For a competitive quotation and other information on services offered by MMIC, please call us at 1-800-328-5532.

MMIC

MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S. Minneapolis, MN 55435-1891

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Consulting Editors
Lenore Franzen
Susan Rodsjo

Assistant Editor
Juliet Ramotar

Public Health Reports Editor
Barbara P. Yawn, M.D., M.Sc.

Graphic Designer
Susan Rodsjo

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine.* The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/DIAL MMA (342-5662).

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine.* Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1996-97 Officers

President
Raymond G. Christensen, M.D.

President-Elect
Kent S. Wilson, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Paul R. Hamann, M.D.

Secretary
Judith F. Shank, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Anthony C. Jaspers, M.D.

Vice Speaker of the House
Blanton Bessinger, M.D.

Past President
Michael J. Murray, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Kendra Flanagan

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth Crabb, M.D.
Theodore L. Fritsche, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/DIAL MMA (342-5662).

Fax: 612/378-3875.

E-mail: mma@mnmed.org

Web site: www.mnmed.org

ASPEN
Medical Group

Family Practice
Full Time Urgent Care

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Internal Medicine
Occupational Health
Ob/Gyn
Pediatrics

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES
OF THE TWIN CITIES

The Right Care . . . The Right Setting . . . The Right Time

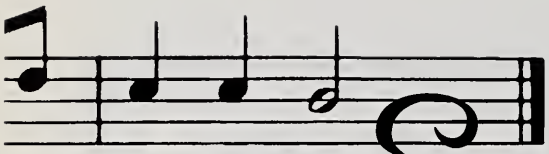


As an extended, critical care hospital focusing on the acutely ill, medically complex patient, THC · Minneapolis aggressively transitions patients to the most appropriate level of care, whether that be a skilled nursing home, subacute facility or home health care. Such was the case with Mr. Ayott, 47 years old, who suffered severe injuries to his chest and lungs in a disastrous car accident. After being stabilized at an acute care hospital, Mr. Ayott transferred to THC to undergo ventilator weaning, wound care, and physical and occupational therapy. With a successful weaning rate of 78% and a new inpatient pulmonary program, THC made it possible for Mr. Ayott to receive the right care in the right setting at the right time.

THC
Minneapolis
A Subsidiary of Transitional Hospitals Corporation

612-588-2750

Medically Complex Program · Pulmonary/Ventilator Program
Wound Care Program · Low Tolerance Rehabilitation Services



Easing performers' pain

As director of Sister Kenny's Instrumental Artists Clinic, Jennine Speier, M.D., helps artists recover from injuries and keeps them performing at their best.

By Kim Palmer

A teenage girl came to Jennine Speier, M.D., complaining of elbow pain. The girl was a cellist whose arm nerves and muscles got heavy workouts when she played. But it wasn't only her artistic endeavors that were contributing to her problem.

"What do teenagers spend a lot of time doing?" Speier asks rhetorically, bending her own elbow to lift an imaginary receiver to her ear. "Talking on the phone. She was stressing that nerve all the time."

Easing performing artists' pain is a complex process of identifying physical actions that have led to the condition and teaching patients new ways of using their bodies. That's what Speier does at Sister Kenny's Instrumental Artists Clinic, which she cofounded in 1988 with Richard Owen, M.D., director emeritus of Sister Kenny Institute.

The clinic includes three physicians and four physical and occupational therapists. "Our secret is to work as a team. The patients know music; we know medicine," says Speier, who is also medical director of Sister Kenny Institute.

"We ask patients, 'What else do you do with your body,' " says Speier, 49, who is board certified in physical medicine and rehabilitation. "I can't just help them at the instrument; I have to help them with the whole picture."

Speier might ask patients to bring their instruments to appointments so she can study how they're using their bodies. "We try to educate them about their body—when to rest, when to use massage," she says.

Sometimes problems can be corrected with equipment, such as using different chin or shoulder rests. Playing habits developed in childhood may have to be unlearned. One therapy Speier has found musicians are very receptive to is biofeedback. "We put patches on the skin over the muscle groups so [patients] can see a digital readout of what they're doing," she explains. "They learn to feel what it's like to use different muscle contraction intensities."

Injuries suffered by performing artists often demand long-term treatment, and that can be frustrating for the artists. "Some problems keep recurring," Speier explains. "We can't cure everything. And just because people have pain doesn't mean they're doing anything wrong."

Performing arts medicine is a relatively new field in the Twin Cites (see cover story, page 16). Speier and her physicians' group, Kenny Rehab Associates, were among the first to get involved. "It was a natural extension of what we do," says Speier. "We were already seeing some performing artists, and we had to deal with the special nature of what they did."

The Musician as Athlete

In describing performing arts medicine, Speier compares performers to athletes. Although musicians rarely think of themselves as athletes, in many subtle ways, wielding a violin bow or playing intensely at an organ keyboard can be just as strenuous and body-punishing as most sports, Speier observes. "People don't recognize the physical demands of being a performing artist." And while athletes enjoy breaks during a typical game or practice, musicians often play for a very long time.

The intense, repetitive motions required to play



most instruments can cause a wide variety of physical ailments similar to those sustained by athletes. According to Speier, string players often develop neck and shoulder problems; keyboardists are vulnerable to tendinitis in a hand or forearm; guitarists tend to have hand and wrist problems; and wind instrumentalists are prone to thumb problems.

Those are some of the most common injuries, but it's far from an exhaustive list. The medical problems Speier sees can be highly individual. Speier cites the dancer she met while on a cruise who was suffering knee discomfort from the physical stress of performing many hours on a moving deck.



PHOTOGRAPH BY JOHN NOLTNER

Pressure to Perform

Performing arts medicine has developed as injuries have become more common, Speier says. "It's a consequence of orchestras having longer seasons and more summer programs. There's more opportunity for overuse."

Pressure to perform typically comes from two sources: organizations and individuals. "Professional orchestras are beginning to recognize the importance of taking breaks," admits Speier, although she is concerned that the message isn't filtering down to high school and college-level programs. "At music camps, sometimes people are playing eight hours a day, plus practice time, up to 12 hours a day. There's peer pressure to maintain that pace, and some camps encourage it, unfortunately."

Speier has even advocated for injured musician-students to sit out from physical education class while they recuperate. "Some teachers think it's just an excuse," she says. "Band and orchestra have to be recognized as activities that promote teamwork and socialization just as sports do."

Occasionally, Speier sees parents who make heavy demands on their children, but more often the pressure comes from the musicians themselves. "The 'stage parent' is rare," she says. "Most young musicians push themselves. The reality of the job market is tough. Only so many people become soloists. It's very competitive, and that puts pressure on people."

To add to these external pressures, performing artists tend to be perfectionists. "They set high standards, and getting them to back off is a challenge. It's hard for them to take time off to allow themselves to heal." Speier says. This is especially true of young musicians. "They're 14 and they think the world will end if they can't play for three weeks."

In Tune with Patients' Needs

Speier did undergraduate work in zoology at Syracuse University and received a master's degree in physiology from Cornell University before attending medical school at the University of Minnesota. In some ways, Speier's rehab work is a continuation of her earlier

interest in comparative physiology and how different animals adapt to their environments.

Before turning her focus to medicine, Speier published a number of physiology papers. "I liked the research, but I missed the people aspect of it," she says. "Now I'm more of a midwife for others' research. I do a tremendous amount of direct patient care."

Speier also has taken her message beyond the clinic. She helped plan and spoke at the past four national Playing (Less) Hurt conferences, which address medical problems unique to musicians. She is in the special interest group on performing arts medicine for the American Academy of Physical Medicine and Rehabilitation. She also holds memberships in two professional groups, the Performing Arts Medicine Association and the International Arts-Medicine Association. "I can remember when I was the only one of two rehab doctors going to meetings," she says, indicating how much the field has grown in the last 10 years.

An upstate New York native, Speier has played the piano since age 6, favoring Schubert and Beethoven. She does not perform, however, and was never pushed to become a virtuoso. "I'd play better if I were more disciplined," Speier says with a smile. Besides, her 70-hour work weeks leave her little time to play.

Speier's busy schedule and experience treating other people's injuries have made her more aware of when her own body is being overused. "I feel shoulder twinges and recognize when I shouldn't be putting as much in my briefcase," she says. "I can get tennis elbow after a weekend of charting.

"Fortunately, medical practice is pretty varied," she adds. She spends about one-third of her time working with performing artists. She also treats car-accident victims, weekend athletes, and patients recovering from polio or a stroke. "I learn techniques relating to one type of injury that I can adapt to other types."

Speier and her colleagues typically see patients over a long period of time. "We're like family practitioners in that we look at the whole person," she says. "That's the appeal of rehab—working together, having individual contact, getting to know the patient, and seeing results." MM

Kim Palmer is a Twin Cities-based free-lance writer.





Ellen's Story

Ellen was a good student in school, active with athletics, academics, friends and family. All that stopped when her chronic pain started — the migraines and severe muscle pain that medications couldn't relieve.

With the help of pediatric experts at Gillette Children's Specialty Healthcare, Ellen has learned to control her pain. And she has returned to her active life.

If your child has headaches, abdominal pain, trauma, musculoskeletal pain, phantom pain or pain secondary to illness, call for the Chronic Pain Program at Gillette.

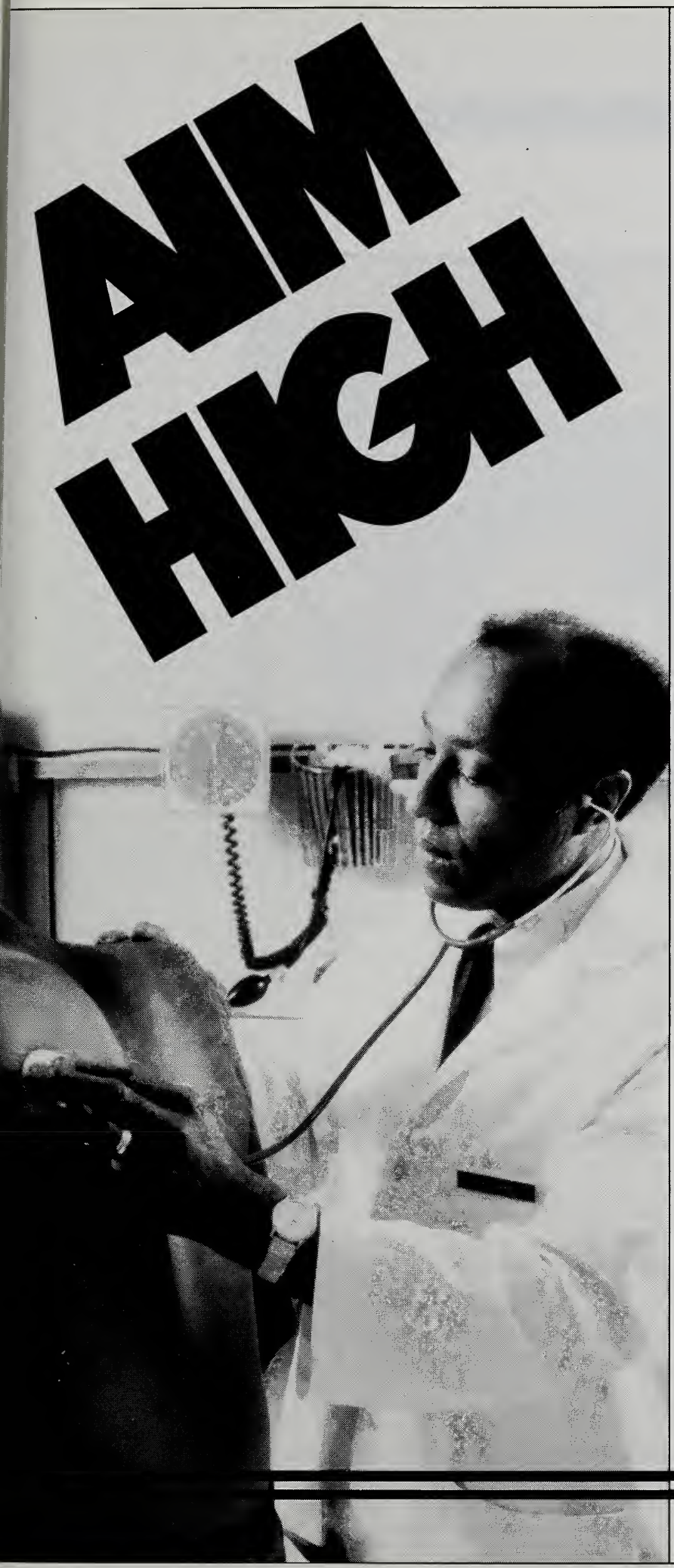
For more information or a referral, call (612) 229-3851

- Cerebral palsy and other neuromotor delays
- Spina bifida
- Juvenile arthritis
- Brain and spinal cord injuries
- Epilepsy
- Complex orthopaedic conditions
- Chronic pain
- Technology dependency

For 100 years, we've been creating new stories every day about our care for kids with chronic conditions.

Gillette Children's
Specialty Healthcare

An Essential Community Provider



SPECIALIZE IN AIR FORCE MEDICINE.

ER Physicians. Radiologists. OB/GYNs and other specialists! Today's Air Force gives you the freedom to specialize without the financial overhead of running a private practice. Talk to an Air Force medical program manager about the tremendous benefits of becoming an Air Force medical officer:

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay each year

Examine your future in the Air Force. Learn if you qualify. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE



ILLUSTRATION BY KARLA ORTLOFF

The Road Best Traveled

Practical strategies to help physicians stay renewed in their careers.

ROBERT L. VENINGA, PH.D.

The practice of medicine has become very stressful. In a survey of 500 physicians in 11 states, almost all reported added stress in their medical practices. The most common causes were dealing with insurance companies and managed care organizations, coping with regulations, and fearing litigation related to malpractice.[1] It's perhaps not surprising that 36 percent of physicians surveyed in another study said they would retire next year if they could. Another 14 percent were uncertain.[2]

The question is: How do you thrive in a stressful career? How can optimism be retained in an era of litigation, financial constraints, and extensive paperwork? And how do you convey hope to patients when you are discouraged? Here are five *practical* strategies to help you stay hopeful in difficult times.

Build leisure into your journey. It may seem unnecessary to remind physicians to care for themselves, but it is advice worth noting. A 36-year-old internist speaks for many doctors when he confides: "I routinely put in 50 to 60 hours a week. I make my rounds early and the rest of the day is spent seeing patients. But before going home, there is another hour of paperwork." He adds: "I'm exhausted, and, frankly, I wonder how long I can keep up the pace."

Hans Selje, a pioneer in stress research, states that each person has an "energy well." When the well becomes depleted, our spirit wanes and our ability to help others diminishes. How best to keep your energy well full? Writer Jean M. Bloomquist advises people to find leisure time in the midst of their busy lives. "Carry plenty of water and drink even when you don't think you are thirsty, because if neglected, the springs of life within us can dry up without our even knowing it."[3]

I have a sign in my office from a bait-and-tackle store in Hayward, Wisconsin. It reads: "When God created earth, he made it two-thirds water and only one-third land. It only seems natural that two-thirds of one's time be spent fishing." I smile whenever I read this sign. Although I cannot spend the majority of my life fishing, the message reminds me of the importance of life's simple pleasures.

How do you build leisure into your journey? Plan vacation days, but spread them out over time. While some people need long vacations, mini-vacations provide a much-needed break. Consider taking three or four days off every two to three months. Make certain that you spend your time doing that which brings joy to life.

Is leisure really important? Chinese philosopher Lao-tzu said: "All action begins in rest ... this is the ultimate truth."[4] If you want to stay healthy when you are under a lot of stress, plan your vacations as carefully as you plan your professional responsibilities. If you do, you will have laid the foundation for preserving your vitality.



Establish priorities. Nearly one-third of the U.S. population does not engage in personal planning. Yet the key to maintaining an optimistic attitude is to set goals that nurture your creativity. I think of a nurse manager who could barely contain her excitement about an innovative staffing plan that improved quality while reducing costs. I think of a high school teacher who discovered that Hollywood films can keep restless teenagers involved in classroom discussions. Or I think of an occupational physician who was enthusiastic about a new chair he designed to eliminate back problems and reduce workers' compensation costs. Whatever your goal, it should challenge your intellect and nurture your creativity.

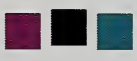
People who are committed to achieving meaningful goals tend to be stress-resilient. In a study of 1,200 individuals who weathered tough times—from divorce to job loss to the death of a loved one—the main factor that enabled them to survive was their wholehearted commitment to reaching a goal. They also relied on strong, caring friendships.[5]

Tremendous empowerment comes from setting priorities. An executive of a Fortune 500 company explains his routine: "The most important part of my day is the first 30 minutes. I write down on a 3 x 5 card what I want to accomplish and I carry it wherever I go. It's like a gyroscope, pointing me in the right direction." Does he always achieve his goals? "No," he chuckles, "there are many interruptions. Meetings are called that I can't avoid. And there are dozens of phone messages that need to be returned. But when I take the time to write down what I wish to accomplish, my day is always more satisfying."



Spend time with your friends. Meaningful friendships do, in fact, keep us healthy. A review of major studies on stress suggests that social insulation is as harmful as smoking, high blood pressure, high cholesterol, obesity, or lack of exercise.[6] Stanford psychiatrist David Spiegel, M.D., found that by spending 90 minutes a week in a support group, women with metastatic breast cancer doubled their average survival time (from 19 months to 37 months).[7] Stage-one melanoma patients who attended a support group had approximately one-third the death rate of patients equally ill who did not participate, according to a five-year study conducted at the University of California–Los Angeles Medical School.[8]

While researchers cannot define how social support systems affect the immune system, this much is certain: People with friends stay healthier, and they tend to retain a more optimistic attitude. As Elton Mayo, M.D., once noted, "One friend, one person who is truly understanding, who takes the trouble to listen to us as we consider our problem can change our whole outlook on the world."[9]



Pick your battles carefully. I once asked a public health administrator how he manages the multiple

pressures in his life with so much grace. He thought for a long moment and said: "I step back and evaluate issues carefully before I get involved. Is this problem worth the fight? Will the outcome affect my organization and our clients? If I did nothing, would the issue go away?

"What I have discovered," he continued, "is that most problems need not be addressed. The ones that matter—and there are usually one or two every day—I get involved in. But only if I think I can make a difference."

Most physicians are very concerned about the vast changes taking place in health care, particularly administrative policies that affect the practice of medicine. Physicians' voices need to be strong and unequivocal, especially when these policies negatively affect their patients' health. But before getting involved, ask yourself, is this issue critical? Will the outcome influence my patients? Do I have the psychological energy to take it on? If the answer to these questions is yes, take decisive action, for few things are more important than speaking the truth. If your response is no—save your energy for a battle that is worth the fight.

Philosopher Bertrand Russell cultivated the habit of thinking the right things at the right time. "The wise man thinks about his troubles only when there is some purpose in doing so," he wrote. "At other times he thinks about other things. When misfortune threatens, consider seriously and deliberately what is the very worst that could possibly happen. Having looked this possible misfortune in the face, give yourself sound reasons for thinking that after all, it would be no such very terrible disaster."[10]

The quickest path toward professional burnout is to spread yourself too thin—taking on too many tasks, trying to solve too many problems. "Yesterday I was hit with a dozen requests," said a 43-year-old cardiologist. "My physicians' group asked me to chair a committee to look at our billing practices. I received

HealthPartners®
St. Paul-Ramsey Medical Center

CME
640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

CONTINUING MEDICAL EDUCATION
1997 FALL/WINTER CONFERENCE SCHEDULE

1st Annual Env. Health Policy Institute ..... September 8-19
15th Annual Occ. Health & Safety Institute ..... September 8-19
Infectious Diseases ..... November 7
Workers' Compensation ..... November 10-11
Strategies in Primary Care ..... November 13-15
Changing General Surgical Practices ..... November 13-14
Cardiovascular Medicine ..... December 4-5
Pediatric Orthopaedic Update ..... December 5

INFORMATION AND REGISTRATION:
Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612-221-3992 • Fax 612-292-4773
St. Paul-Ramsey Medical Center/Ramsey Clinic/Ramsey Foundation are Members of the HealthPartners Family of Health Care Organizations

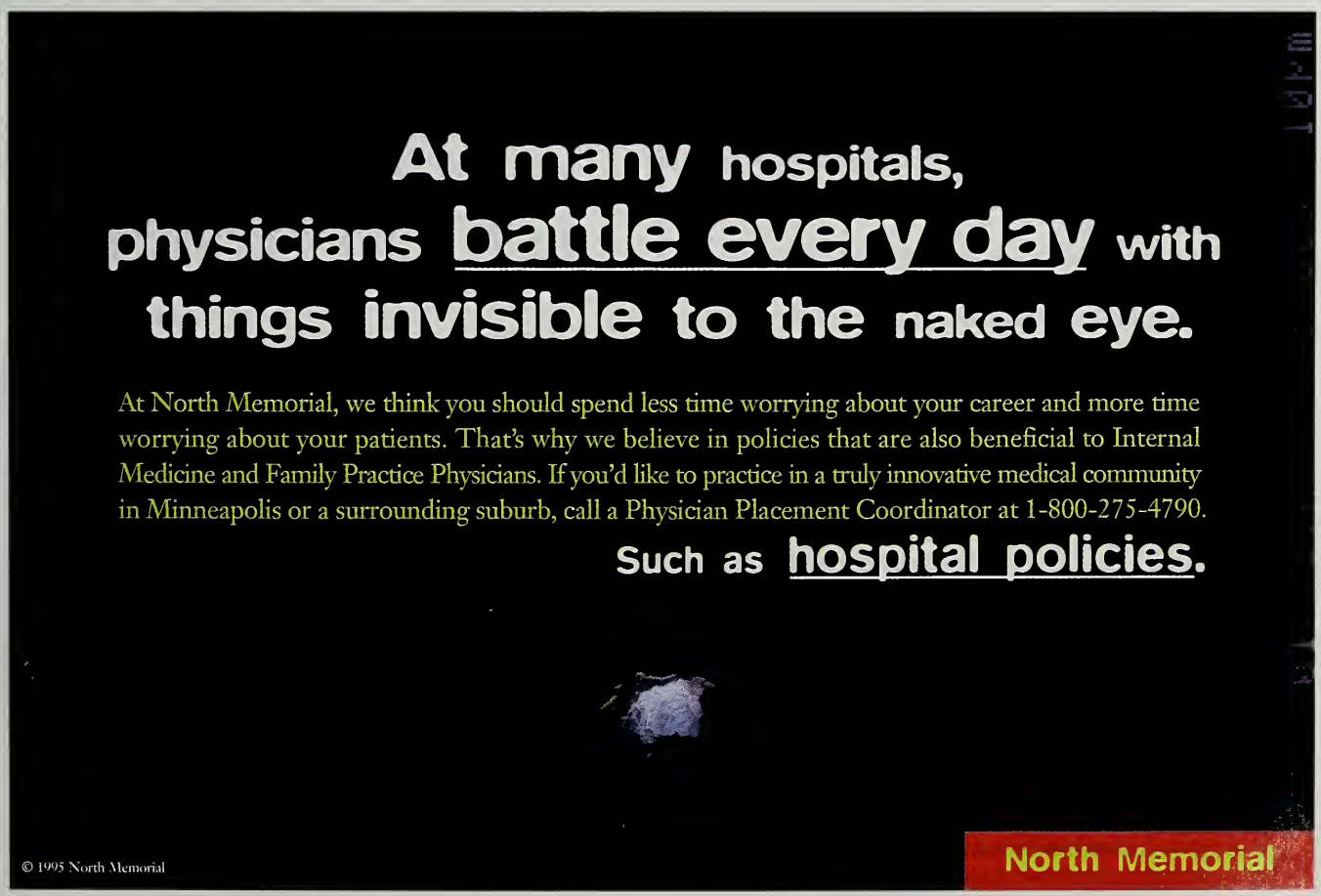
RAMSEY

a call from my priest, who wants me to chair the parish's annual fundraising program. My son called and asked if I could be an assistant coach for his Little League team. Five years ago, I would have said yes to all those requests. After all, aren't they all important? But I've learned you can't take everything on and be effective. So I told them I'd think about it and would call them back.

"The only additional thing I'm going to take on is coaching. I know that my physician friends and the office administrator won't like it, and the priest will be disappointed. But I'm going to be a bit selfish and think about my own health."[11]

Keep learning, growing, and being excited about your career. In T.H. White's wonderful novel, "The Once and Future King," Merlyn says: "The best thing for being sad is to learn something. That is the only thing that never fails. You may grow old and trembling in your anatomies, you may lie awake at night listening to the disorders of your veins, you may miss your only love, you may see the world around you devastated by evil lunatics or you know your honor trampled in the sewers of baser minds. There is only one thing for it then—to learn. Learn why the world wags and what wags it. That is the only thing which the mind can never exhaust, never alienate, never be tortured by, never fear or distrust, and never dream of regretting. Learning is the thing for you."[12]

Despite the problems that surround us, we live in an era in which new knowledge is produced daily. Eighty-five percent of all scientists who have ever lived are alive today. The time between the realization of an idea and its arrival in the marketplace is now the shortest in history—usually only a few months. From the time of Christ's birth to the middle of the 18th century, knowledge doubled. It did so again 150 years later and then again in only 50 years. Today it doubles every four or five years.



The significance? Physicians are in the forefront of discovering and dispensing life-saving knowledge—knowledge unique to their profession. To make things even better, that knowledge is exciting and ever-expanding. It is breathtaking to think of the recent progress made in surgical techniques, medications, and treatment modalities. Futurists tell us, however, that the discoveries of the last 10 years will be nothing like the changes of the next decade as new pharmaceutical agents, surgical instruments, and techniques move from laboratory to market. Granted, there are many frustrations in the practice of medicine. But the rewards will be great in the years ahead as new knowledge enables you to help your patients improve the quality of their lives.

How best to maintain a healthy professional life? How do you stay renewed given the pressures of modern-day medicine? *Build leisure into daily routines. Establish priorities. Make time for your friends. Pick your battles carefully. Never stop learning.* For if you do these things, stress will be diminished. And you will find new joy in your journey. MM

Robert Veninga is a professor in the School of Public Health and author of four books and over 60 articles focusing on stress, organizational change, and career renewal. He is listed in Who's Who in Health Care *and Who's Who in U.S. Writers, Editors, and Poets.*

REFERENCES

1. Levy D. Managed care has doctors struggling. USA Today 1996 Sep 3:6D.
2. American Medical News 1990 Oct 19:32.
3. Bloomquist JM. Holy time. Weavings 1991 Jan/Feb 6:13.
4. Bloomquist H, Kory R. The holistic way to health and happiness. New York: Simon and Schuster, 1978:43.
5. Veninga R. A gift of hope: how we survive our tragedies. Boston: Little, Brown and Company, 1985:154-79.
6. People who need people. Psychology Today 1988;11:8.
7. Spiegel D, Bloom JR, Kraemer HC, Gottheil E. Effect of psychosocial treatment on survival of patients with metastatic breast cancer. Lancet 1989;11:888-91.
8. Contavespi V. Faith healing. Forbes 1994;5:48.
9. Mayo E. In: Borman E, Nichols R, Shapiro G, eds. Interpersonal communication in the modern organization. Englewood Cliffs, NJ: Prentice-Hall, 1969:178.
10. Russell B. In: Goldberg P, ed. Executive health. New York: McGraw-Hill, 1978:113.
11. Veninga R, Spradley J. The work/stress connection: how to cope with job burnout. Boston, MA: Little, Brown and Company, 1981:254.
12. White TH. The once and future king. New York: Putman, 1958:126.

Family Practice Variety

HealthPartners has a variety of opportunities for BC/BE family practitioners. These are primarily adult practices, some full range and some limited range, most in ambulatory settings. Urban or suburban practices are available.

HealthPartners Bloomington Clinic
Large suburban clinic located in Bloomington, just south of Minneapolis.

HealthPartners Riverside Clinic
Just outside of downtown Minneapolis, this clinic serves a widely diverse population.

HealthPartners Skyway Clinic
Downtown Minneapolis clinic practice involving no OB and limited peds.

HealthPartners Woodbury Clinic
Our newest clinic, located in the fastest growing suburb of St. Paul. Full range practice.

Ramsey Clinic Maplewood
Suburban location with a full range practice including peds with OB optional.

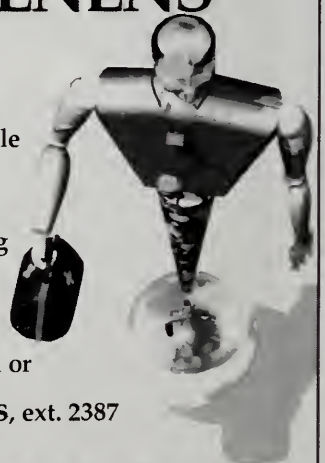
For more details on specific openings and clinic sites, contact Lori Fake at (612) 883-5337 or (800) 472-4695. For consideration, forward your CV to: HealthPartners, Physicians Services, P. O. Box 1309, Minneapolis, MN 55440-1309. EO/AA Employer.

HealthPartners

HealthPartners' mission is to improve the health of our members and our community

Staff Care, Inc.
"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS



- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging

Ask for :
John Moberly, ext. 2381 or
Melanie McReynolds, ext. 2387

(800) 685-2272
http://www.locumsnet.com

Staff Care is proud to sponsor *the Country Doctor of the Year Award*

Unable to place J-1 or H-1 physicians

Members of the Minnesota Medical Association are saving money on their workers' compensation insurance premium costs with the Dodson Plan!

Minnesota Medical professionals were paid a 15% dividend totaling more than $148,000.00 in 1996! In fact, participating members have received dividends 21 out of 25 years with Dodson Group!

In addition to yearly dividend opportunities, MMA members receive:

COMPETITIVE RATES. A 15% discount is applied when policies are issued.

PERSONALIZED SERVICE. Our home office and field staffs are experienced and professional. They work closely with you, addressing your questions and concerns.

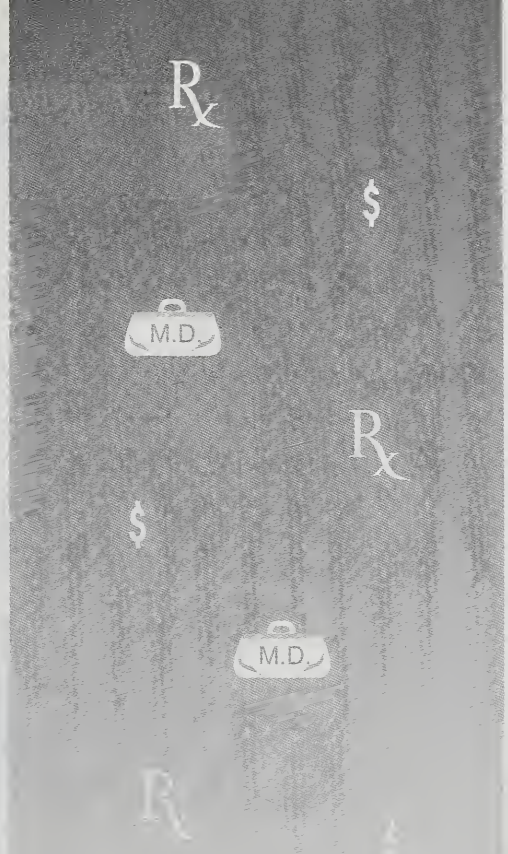
INTEREST-FREE PAYMENT PLAN. The Plan is designed to give you flexibility in paying your insurance premiums with interest-free installments!

OUTSTANDING CLAIMS MANAGEMENT. Our progressive managed care program gives you access to two of the largest PPO networks in the country.

A CENTURY OF EXPERIENCE. Dodson Group insured its first customer in 1900 and its first MMA members in 1972! Today, that experience works for you!

DODSON GROUP

*State laws prohibit insurance companies from guaranteeing future dividends.



Get the Facts!

MMA members can receive a free no-obligation premium quote . . . just call or FAX Dodson Group today!

CALL: 1-800-825-9489

FAX: 1-800-825-6035

Visit our Web site: http://www.dodsongroup.com

PHYSICIAN APPROVED MMBR ASSOCIATION ENDORSED

Dodson Group has been the preferred provider of WC insurance of the Minnesota Medical Association since 1972.

Performing Arts Medicine CRESCENDOES con Spirito



Tuned in to the special needs of their artist patients, performing arts physicians work together to keep their patients in the spotlight.

Michael Adams stood outside a Boston performing arts medical clinic shedding tears of relief that years of pain were about to end. It was the early 1980s, before performing arts medicine existed in Minnesota. Adams, a Minnesota Orchestra violin player, had haunted Twin Cities clinics in search of a cure for his debilitating lower extremity pain. "I received a

By Howard Bell



spectrum of diagnoses," he says. "It was amazing what [the doctors] came up with."

In Boston, a performing arts neurologist correctly diagnosed thoracic outlet syndrome. The nerve compression disorder rarely manifests in the lower extremity, which made diagnosis difficult. Surgery restored Adams' ability to perform. "We didn't have to start from scratch on how you hold a violin," Adams says of the therapy he received at the Boston clinic. "I immediately noticed a difference. [The Boston physicians] were more sympathetic. They knew what musicians go through. For as well-educated as doctors are, it's amazing how little they know of basic biomechanics of playing an instrument."

Performing arts medicine came into its own about 15 years ago, after Leon Fleischer's tragic experience drew attention to the need. Fleischer, a New York concert pianist, suffered debilitating hand contractures caused by overpractice. "He was the greatest piano virtuoso to emerge in years," says Jon Hallberg, M.D., a performing arts physician with Fairview Nicollet Medical Mall Clinic. "He couldn't find anyone to help him and now can only



Photographs of pianist Jean Krinke (above) and harpist Frances Miller (right) by John Noltner.

play with his left hand. His unfortunate experience got medicine's attention."

Without residency programs or fellowships, performing arts medicine cannot be considered a full-fledged subspecialty. It does, however, have its own annual meeting, held each summer in conjunction with the Aspen Music Festival in Colorado. The field has at least three journals and two medical societies, the Performing Arts Medicine Association and the International Arts-Medicine Association. Physicians have at least one medical resource, the "Textbook of Performing Arts Medicine" (see sidebar, page 21).

The Minnesota Performing Arts Medicine Scene

In the early 1990s, performing arts medicine in Minnesota consisted of a handful of physicians working independently and with little support. Today, a growing number of Twin Cities physicians specialize in treating dancers, musicians, singers, and actors. Minnesota also has two multispecialty performing arts medicine centers: Fairview Arts Medicine Center (FAMC) and the Instrumental Artists Clinic, part of Abbott Northwestern's Sister Kenny Institute.

FAMC is only 8 months old and will not have its official grand opening until next fall, according to Hallberg. Fairview's center is really four separate clinics: Fairview Nicollet Medical Mall Clinic, the Voice Center of Fairview, Fairview Hand Center, and the Minneapolis Sports Medicine Center's Dance Program. Each has operated independently for as long as eight years, but now FAMC coordinates referrals and is standardizing protocols.

Physicians can refer patients directly to any of the four clinics or call the Fairview Nicollet clinic, which triages referrals into the system and, with its 888 information and referral phone number, encourages consultations from outstate and beyond. "Physicians tend to refer the tough cases to us," says Hallberg. "We get many self-referrals, too."

Sister Kenny's Instrumental Artists Clinic is 8 years old. Physiatrist Jennine Speier, M.D., heads the clinic, which includes two other physical medicine and rehab physicians, Barbara Seizert, M.D., and Nancy Hutchison, M.D.

The Artists Clinic and FAMC have separate, though sometimes overlapping, networks of providers: primary care physicians, hand surgeons, orthopedists, neurologists, neurosurgeons, dentists, chiropractors, and physical, speech, and occupational therapists. Physicians and therapists involved usually have some special knowledge of performing arts or are themselves part-time performing artists.

Speier, for example, is a pianist. So is performing arts neurologist Frederick Langendorf, M.D., with Hennepin County Medical Center. Joel Boyd, M.D., an orthopedist with Fairview's Dance Program, was the Cleveland Ballet's physician when he trained at the Cleveland Clinic. FAMC's dentist is a classical trumpet player. Hallberg is a sax player with the Minnesota Symphonic Winds. He's also an avid film buff who has served as set physician for

Health Sciences & Human Services Library

every film recently produced in the Twin Cities.

Minnesota's two multispecialty performing arts centers have their own strengths, according to Hallberg, so it makes sense for them to cooperate. FAMC describes itself as a clinic without walls. Fairview Nicollet, for example, handles "whole-body illness issues" and refers patients to appropriate specialists after doing a comprehensive history and physical. Fairview's Dance Program is part of the Minneapolis Sports Medicine Center, which remains independent of the Fairview Health System.

FAMC hopes to house the Voice Clinic in a West Bank church near the University of Minnesota's School of Music and plans to rotate FAMC physicians through the clinic once or twice per week. The center may eventually house an arts therapy clinic. "Our goal," says Hallberg, "is to establish a regionwide reputation and to be the nation's first truly comprehensive arts medicine program. We will rely on the best expertise in the Twin Cities, regardless of affiliation."

Sister Kenny's focus is on preventing and rehabilitating neurologic problems and musculoskeletal injuries that have biomechanical causes. Most of their patients are musicians with upper-extremity injuries, although they also see dancers, skaters, singers, and visual artists, such as sculptors.

Small Muscle Olympians

Hallberg, who calls performing artists "Olympians of small muscle groups," says small-scale problems become serious if left untreated. "It's crucial to carry out modalities quickly," he says, "which is more efficiently accomplished by providers trained in performing arts medicine."

Speier says knowledge of an artist's field makes diagnosis easier, especially for soft tissue injuries that don't show up on scans and x-rays. "The key for soft tissue diagnosis is a good history and analysis of body position while playing the instrument." ⇨





Christopher Watson of the Christopher Watson Dance Company.

Performing arts medicine is a mix of sports medicine and occupational medicine. "Every day we read in the paper about athletes sidelined with injuries," says Hallberg. "It happens to performing artists, too, but we don't always read about it." Performing arts physicians train themselves to know what it takes physically and mentally to play an instrument, dance in a ballet, sing opera, or act in a film or on stage.

The goal, according to Speier, is to avoid delayed treatment, which worsens small muscle problems. "We do see many people who spent months going to other specialists," says Speier. "The quicker we can see them, the better." One of Speier's patients with nerve entrapment had been put on a strengthening program, which exacerbated the problem. Speier referred her to an Artists Clinic hand surgeon, who restored full performance capability. Without referral to a performing arts program, says Speier, the patient's career and any use of her hand might have ended.

"It helps to have some insight into the pressures performing artists face," says Hallberg. "You need to understand the salaries involved, the risk-to-benefit ratios of performing while injured or sick, to know which medications least harm performance, how much an instrument weighs, how the body is stressed when playing it, and what it's like to be in a highly competitive field where 2,000 musicians may apply for one orchestra chair or 200 actors audition for one part."

For dancers, performing arts medicine is customized sports medicine, according to Rochelle Taube, M.D., with France Avenue Family Physicians. She applied her sports medicine fellowship training to help create Fairview's Dance Program, which she describes as a loose collection of physicians and therapists with performing arts expertise. "The biggest myth is that dancers are artists, not athletes," she says. "They are year-round athletes with no off-season and very high overuse injury rates."

Taube used to treat dancers who had asthma, diabetes, eating disorders, and amenorrhea. She now does orthopedic dance evaluations for patients with knee problems, hip and balance kinetic problems, and Achilles tendinitis.

Fairview's Dance Program works with local dance companies like Ballet of the Dolls and Zenon. They are on the "call first" list for visitors, such as the New York Ballet, Alvin Ailey Dance Company, and megamusicals like "Miss Saigon." "We're focused on dance injury patterns," says Boyd, an orthopedist with the program. "We think like dancers think. We understand that despite their extreme flexibility, a 5 to 20 degree loss of motion range is significant. Injured dancers are afraid we'll

make them rest, but we understand rest is often not an option." Fairview's program uses Pilates dance therapy, which Boyd describes as a strengthening and preventive exercise program for dancers.

Artists Share Their Stories

Sally Rousse, a professional dancer with the James Sewell Ballet in Minneapolis, likes dance medicine's focus on prevention. "They teach us to recognize and interpret what our bodies are doing and how hard to push. When you know what's wrong, you dance better, because you're not as scared."

Rousse, who's danced for 25 years, prefers to see only doctors trained in dance medicine. "They know how to tape you and are sensitive to how precisely we must move. They know when we're pronating. They know when we're injuring ourselves by wearing soft-point shoes past their prime."

David Buran, M.D., a Park Nicollet otolaryngologist, is a choral singer who treats Minnesota Opera Company singers, jazz and nightclub singers, and actors and voice students of all ages and achievement. "Having firsthand experience with opening night stress and long runs helps me care for them," he says. "It helps to know that Chanhassen actors are doing eight shows per week in a dry theater. I think I approach their problems with greater enthusiasm because music is important to me and I have a passion for what's going on with these performers."

Dede Jorstad is a believer. The Minnesota Opera Company mezzo-soprano battled a swollen throat on the eve of performing Annina in "La Traviata." "Dr. Buran understood the immediacy of care needed and what to give me so I could sing through it," she says. "I get the feeling they [physicians trained in performing arts medicine] understand how obsessive singers are about their throats."

Pressures for perfection inflict serious, often career-ending injuries. In the Oscar-winning movie "Shine," young virtuoso David Helfgott prepares to perform Rachmaninoff's 3rd Piano Concerto. "People hurt themselves," his teacher warns him about pianists who attempt the difficult piece. With that perfunctory caution out of the way, his teacher advises Helfgott to "play as if there were no tomorrow." ⇨

Performing Arts Medicine Resources

Sister Kenny's Instrumental Artists Clinic
612/863-4495

Fairview Arts Medicine Center
888/750-ARTS

Performing Arts Medicine Association
716/275-2679

International Arts-Medicine Association
610/525-3784
http://members.aol.com/IAMAorg

Society for the Arts in Healthcare
(Duke University School of Medicine)
919/286-3361
http://152.3.64.222/depts/cs/healtharts/brochure.html

"Textbook of Performing Arts Medicine"
(New York: Raven Press, 1991). First clinical journal to address etiology, diagnosis, and treatment of medical and psychological disorders and diseases related to performing artists.

Music Medicine Clearinghouse
410/539-0872

Performing Arts Health News
212/246-0557

International Journal of Arts Medicine
800/543-3771

"The Musician's Survival Manual: A Guide to Preventing/Treating Injuries in Instrumentalists"
by Richard Norris, M.D. (S.L.: International Conference of Symphony and Opera Musicians, 1993)
800/543-3771
mmbmusic@mmbmusic.com



Photos above and on pages 16, 17, and 23 from the James Sewell Ballet's "Moving Works," 1996. Dancers Penelope Freeh, Joel Klausler, Sally Rousse, Christian Burns, Anna Laghezza, and James Sewell. Photo by Erik Saulitis.

The Cost of Not Performing

That particular scene also illustrates the dilemma performing arts medicine practitioners confront when they try to balance their patients' medical needs with the realities of contracts and performance dates. "Finding the balance is key," says Hallberg. "You have to weigh healing time against money and time pressures on the artist."

Hallberg felt a bit like the star himself on the set of "Grumpier Old Men," when one of the grumpier old men was ailing. The director, assistant director, and cinematographer waited anxiously for Hallberg to emerge from the star's trailer. Hallberg prescribed a day of rest. "My decision cost the production $100,000," says Hallberg.

Even minor ailments can be serious to performing artists. When doing preproduction film physicals, companies insuring the productions require Hallberg to ask actors if they've had a cold sore within the last six months. Cold sores make close-ups out of the question and cost thousands of dollars in delays.

"If I get a paper cut, I'm out of business," says Janet Horvath, coprincipal cellist with the Minnesota Orchestra. Horvath is a nationally known speaker on performing arts medicine who founded "Playing (Less) Hurt," a series of conferences for physicians and musicians held at the University of Minnesota and elsewhere. She also consults with the Instrumental Artists Clinic and is on the FAMC board. "An ear infection to a professional musician is critical," Horvath says. She even recalls a flutist who missed a performance because of a canker sore.

Playing Through the Pain

According to a U.S. Orchestra Association membership survey, 60 percent of the nation's orchestral musicians say they've played in pain. In fact, orchestral musicians have one of the highest rates of occupational injury, according to a survey conducted by the International Congress of Symphony and Opera Musicians. Seventy-six percent of orchestral musicians have experienced occupational injuries severe enough to force them to stop playing at least once during their career. Three-quarters of professional cellists have experienced back pain severe enough to affect performance; for harpists, it's 73 percent; pianists, 69 percent; bass players, 60 percent; and violinists, 37 percent.

Brass players in concert display marked cardiac arrhythmias and heart rates as much as 80 percent faster than normal, according to a study by the Institute for Mental Health in Washington, D.C., which specializes in stress management in musicians and treatment of performance anxiety. Professional musicians as a group have a 5 percent higher incidence of coronary disease. They also have a 20 percent lower life expectancy, though no one knows why. Horvath says it's physical and psychological stress.

Hallberg says he doesn't doubt these statistics. "Performing artists are regular people who suffer the pitfalls of daily living compounded by pressures of performing."

No numbers are available, but anecdotally, physicians say performing arts injuries are on the rise. Performing artists, like athletes, keep raising their standards, pushing their bodies and mental health beyond endurance. "Musically, we long ago passed the four-minute mile," says Horvath. "Orchestras used to consider Stravinsky's "Rite of Spring" an impossibility. Now it's a standard part of repertoires. We've got 10- and 12-year-olds playing Tchaikovsky concertos. We're performing three-hour concerts."

The Minnesota Orchestra, among others, has forsaken traditional 26-week seasons for grueling 52-week schedules. "Our bodies never get a chance to rest," says Horvath. "It's not unusual to rehearse six to eight hours a day." Meanwhile, audiences and conductors are demanding "bigger and louder" as concert halls grow in size and audiences expect CD-quality sound.

"I cannot name a sport," says Speier, "that exceeds the physical demands of being an orchestra string musician."

Performing music requires high-speed repetitive motions for long periods. Horvath counted her arm moving back and forth 720 times during a three-minute movement of Handel's *Messiah*. Shopping mall pianists performing for six hours press the keys 18,000 times per hour. At eight ounces of force each press, their hands endure 54,000 cumulative pounds of pressure.

Speier says the Sister Kenny program has sensitized its consulting surgeons to biomechanical demands performing artists endure. "Our surgeons really relate when we remind them that playing the violin professionally is like doing delicate microsurgery." One of Speier's patients, a professional singer, needed cervical disk surgery. He was concerned the anesthesia tube and surgical approach would harm his voice. His hometown doctor did not take his concern seriously. "We worked with the anesthesiologist and neurosurgeon to modify the surgical approach and insert the most appropriate tube," says Speier. "You have to consider an individual's career and talents."

The Instrumental Artists Clinic prescribes an array of special chairs, supports, straps, and braces designed to overcome ergonomically incorrect musical instruments. "It's very helpful when doctors are up on the latest orthotics," says Horvath. "It helps when your physician understands how a tiny thing—a little turn in the torso or tension in the hand—can affect you. Performing arts medicine is no different from sports medicine. We need people who know and understand what we do." MM

Howard Bell is a free-lance writer living in Onalaska, Wisconsin.



Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.

3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

A Good Walk Spoiled[1]

Golf's Links to Medicine

Douglas D. Brunette, M.D., F.A.C.E.P.

ABSTRACT

This article explores the game of golf as it appears in the medical literature. Included are sections on the historical interaction of golf and medicine, the physiology and performance of golf, illness and injury related to golf, environmental concerns involving golf course management, physical disabilities, medical research and golf, and specific medical specialty references to golf.

Golf and medicine are uniquely intertwined. A search of MEDLINE beginning in 1966 yielded 255 references related to the game. Whether you are a nongolfing medical practitioner who espouses the Mark Twain[1] view of golf, or an avid player who views golf as a metaphysical event, it is difficult to deny golf's association with medicine.

Minnesotans in particular have a strong interest in the game. According to the National Golf Foundation, 20.2% of Minnesota residents age 12 and older play golf, ranking Minnesota second highest in golfers per capita in the nation.[2] Minnesota is also the only state to have hosted each of the 13 different U.S. Golf Association-sponsored championships at least once.[3]

This article explores the game of golf as it appears in the medical literature. Included are sections on the historical interaction of golf and medicine, the physiology and performance of golf, illness and injury related to golf, environmental concerns involving golf course management, physical disabilities, medical research and golf, and specific medical specialty references to golf. This article has information useful to physicians who golf, and to those providing medical care to patients who golf.

Historical Information

The earliest written record of golf dates to 1457,[4,5] while the earliest known written regulation of the practice of medicine is the Code of Hammurabi, in cuneiform, circa 1700 B.C.[6] Since the advent of the game, golf and medicine have interacted frequently.

Before 1922, golfers would build a small mound using either dirt or sand to enable a good lie of the ball on the first shot of every hole (tee shot). This method required that sand or dirt be available on every hole, and golfers dirtied their hands and clothes. In 1922, dentist William Lowell, D.D.S., designed a cone-shaped wooden peg with a small concave platform. Two years later, he patented the design, and it became the world's first commercially produced golf tee. It did not become popular until the great Bobby Jones used it in a tournament. Dentists seem to have a propensity for golf tee design. The very first golf tee had been patented by another dentist, George F. Grant, D.D.S., in 1899.[7] However, his tee was never commercially manufactured or marketed. The most recent dentist to tinker with golf tee design is Arnold DiLaura, D.D.S., who patented Sof-Tee, a tee that sits on top of the ground instead of in it.[7,8]

Sir Harold Gilles, historically noted to be the father of plastic surgery, was an avid golfer. His golfing exploits include membership at the Royal and Ancient Golf Club at St. Andrews, a 2 *below par* handicap, and a victory in 1913 at the St. Georges Grand Challenge Cup in Sandwich, the most coveted amateur championship of England. His medical accomplishments include starting a reconstructive surgical unit in Sidcup, England, at the end of World War I, considered to be the first plastic and reconstructive surgery center in the world.[9] Sir Gilles reportedly performed a breast reduction on a female golfer who complained that her breasts encumbered her golf swing. Her handicap is said to have dropped to a 6 postoperatively.

Every year since 1890, with short pauses for world wars, an interesting interaction occurs between golf and medicine. In 1890, the Royal Colleges Golf Club was formed.[10] Its mem-

bers are from the Royal College of Physicians (founded in 1681) and the Royal College of Surgeons (founded in 1706). Each year the two colleges played a golf match, which has added much spice to Edinburgh medicine.[10]

More recently, medical organizations commonly use golf tournaments as a means of raising funds.[11] A standing, and questionably unfounded, joke says that it is nearly impossible for patients to communicate with their private physicians on Wednesday afternoons. The merits and frequency of physicians playing golf have even been the subject of letters to the editors of medical journals.[12-15] One recent article[16] estimated approximately $1 billion is spent annually to produce and send 153 million pounds of unsolicited mail to U.S. physicians. Included in the category of "junk" mail in this study (and arguably so from a golfing practitioner's standpoint) are golf tees.

Physiology of Golf

The majority of medical literature related to the physiology of golf focuses on the electromyographic (EMG) study of the golf swing, metabolic response to golf participation, and the kinematic analysis of the swing.

Researchers have performed several EMG studies of the hip, knee, trunk, shoulder, and upper extremity.[17-24] These studies delineate the role of various individual muscles in the golf swing in order to develop exercise programs for optimal performance and prevention or rehabilitation from injury. Among the findings are the discoveries of the importance of the scapular and trunk muscles in the golf swing[18,25] and the sequential firing of the hip and knee muscles relative to the trunk and shoulder muscles in a competitive male golf swing.[17] The subscapularis is the shoulder muscle most active during the golf swing; the latissimus dorsi and pectoralis muscles provide power bilaterally.[19,23,24] The infraspinatus and supraspinatus fire at a relatively low rate and at the extremes of range of motion.[21,23,24] The deltoids add relatively little to the motion of the swing.[21,24]

Studies noted no difference in EMG shoulder activity between male and female professional golfers.[22] Golf is different from other upper-extremity sports in that the deltoid is relatively quiet despite a very active rotator cuff musculature.[24] Conditioning of the rotator cuff, latissimus dorsi, and pectoralis major muscles would benefit performance.[19,23,24] One reference noted that rotator cuff injuries tend to occur in the left shoulder of righthanded golfers.[21] EMG analysis of specific shoulder rehabilitation and strengthening exercises has outlined the best exercises for the muscles most important in golf.[20]

The caloric cost of playing golf[26-31] and its physiologic benefits[32,33] have been studied. The caloric cost of golf is 3.6 to 6.0 kcal/min, with total energy expenditure estimated between 622 to 960 kcal per 18 holes.[26-28,30] Golf traditionalists espouse walking and carrying one's own clubs. Carrying golf clubs has been shown to cause a 15% increase in oxygen consumption, a 25% rise in minute ventilation, and a 10% increase in kcal/min expended compared with normal walking.[30,34] Two separate studies examine leisure-time physical activity that includes golf. One ongoing study involves adolescents and is exploring the relationship between leisure-time sports participation and eventual health outcomes as measured at the age of 18 years.[32] A second study of leisure-time activity revealed an inverse relationship between physical activity quartiles as measured by kilocalories expended per year and the cardiovascular risk factors of high-density lipoprotein cholesterol, heart rate, body mass index, and cigarettes smoked.[33]

Researchers have also done a kinematic analysis of the golf swing and its components.[35,36] Other kinematic studies have looked for racial differences, driver vs. nine iron differences, and wrist action during the golf swing.[37-40] Scientists have even reviewed a computer simulation of the biomechanics of golf.[41]

Several miscellaneous studies focus on the physiology of golf. Mean heart rate during a round of golf is 108 beats/minute.[26] Blood pressure, pulse, cholesterol, blood sugar, uric acid, and vanillylmandelic acids have been monitored before and after an 18-hole golf match.[31] In this study, cholesterol, blood sugar, and uric acid tended to increase, while vanillylmandelic acids decreased. Carrying golf clubs for nine holes has been shown to cause a 4.76mm shrinkage in stature, associated with loss of intervertebral height.[34] Playing golf increased total serum creatine phosphokinase and myoglobin, but not troponin-T.[42] In another study, serum glucose decreased and free fatty acids increased during 18 holes of golf.[26] Female golfers were included in a study analyzing age of menarche and menstrual characteristics.[43] Researchers have studied highly skilled golfers' electroencephalographic measurements of the motor and temporal cortices, indicating attentional patterns, in the 3 seconds immediately prior to golf putting.[44,45] In this study, left hemispheric cortical activity decreased as the player prepared to putt, with a concomitant significant increase in the right motor and temporal cortical activity. During the last second preceding the putt, golfers showed an increase in right hemispheric alpha activity, the magnitude of which correlated with increased putting success.

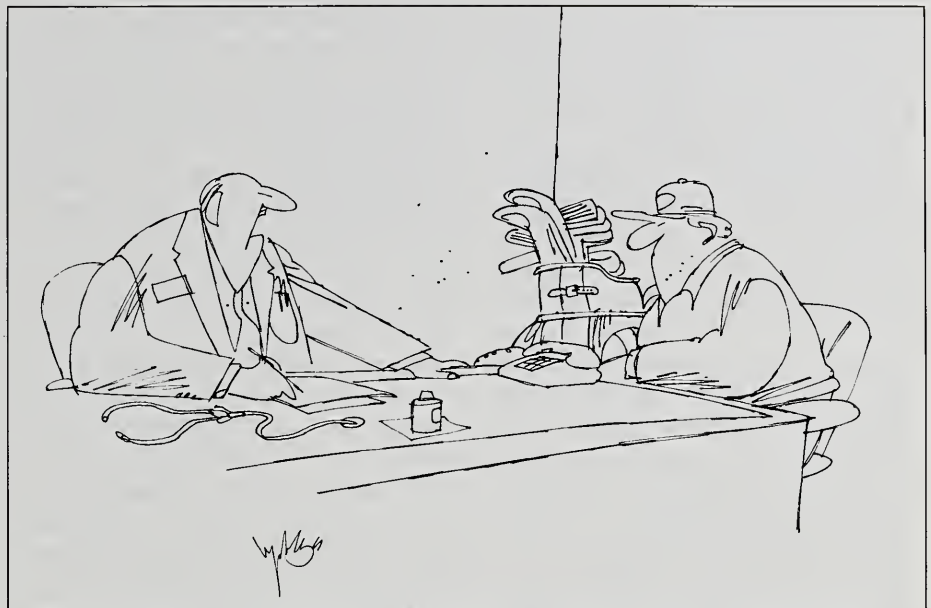
Performance of Golf

Medical researchers have studied the age-related decline in the physical and mental skills required for skillful golf.[46-55] In a series of experiments using highly skilled miniature golf players, a research group demonstrated that during training and competitive conditions, younger and older players had a similar increase in heart rate and anxiety ratings.[47,48,52] However, under competitive conditions, younger players improved their motor performance while older players showed a decline. These studies suggest that the decline is due to age-related deficits in a variety of basic cognitive functions activated in high-arousal conditions.[47,48,52,53]

Additional studies point to an age-related decrease in attentional functioning.[49,50] However, one study demonstrated that age-related impairment in some golf skills can be compensated for by greater reliance on skills that are maintained or improved with age.[46] In this study, younger and older golfers of equiva-

lent handicaps were examined to identify age-related differences in psychomotor skills. Older golfers drove the ball a shorter distance, adopted a more conservative approach to shotmaking, and reported fewer negative emotions and cognitions related to their performance.[46] In other words, age, wisdom, and experience can compete with youth, skill, and inexperience. Peak golf performance occurs at the age of 31.[51] Despite the age-related decline in technical skills, golf, in comparison to most other sports, remains suitable for the older individual. One study found that general motor performance skills of older women golfers was significantly better than those of older inactive women.[55]

A number of golf performance articles relate to ophthalmology and stress the importance of vision and proper eyewear.[56,57] Several studies have addressed putting skills relative to ophthalmologic principles. Beginning golfers might learn and enhance their putting skills by occluded vision techniques.[58,59] Another study showed that putting is superior when the golfer looks at the ball rather than at an irrelevant target or no target at all.[60] Studies have also demonstrated the influence of head position in putting skill.[61,62] The effect of eye and hand dominance affects putting skills at different head positions.[61] Pure dextral golfers (right-eyed and right-handed) were found to have fewer putting errors if their eyes were positioned halfway between the ball and their feet rather than focused directly over the ball.[61] Ocular factors in successfully lining up a golf shot, as well as gaze movement during putting, have also been addressed.[63,64] During putting, more accomplished golfers tend to fixate longer on the ball and target, with fewer fixations on the club and surface.[64] Greater putting success was associated with express saccades to the club during preparation, a steady fixation on the ball during the actual swing of the putter, and fixation on the surface during ball contact.[64] Dark-eyed individuals perform better at reactive task sports (boxing, hitting a ball), and light-eyed individuals perform better at self-paced task sports (bowling, golf).[65]



"They don't make a transdermal patch to help you stop slicing; if they did I'd be wearing one ... "

Additional studies have addressed golf performance and certain personality traits, various methods of skill improvement related to different methods of instruction and feedback,[66-72] biorhythms,[73] training aids,[74,75] equipment,[76-79] nutrition,[80] grip method and grip pressure,[81-83] weight shift,[84] and a theoretical analysis of aggressive golf putts.[85]

Two miscellaneous performance topics stand out. The first involves cognitive processes and the effects on motor performance, concentration time, and perceived difficulty.[86] In this study, highly skilled miniature golf players were examined on a simple miniature golf task under different instructional conditions. When players were asked to attend to a variety of technical aspects of the game, motor performance was impaired in the players who ordinarily do not use the given cognitive processes but not impaired in the players who do. Overall, increasing cognitive demands were associated with a decline in motor performance, and directing cognitive attention toward the technical aspects of the game interfered with players' normal cognitive activity. Proper execution of a swing lends itself to a detailed analytic approach, and golfers aptly call the phenomenon "paralysis by analysis."

Important to a number of professional and amateur golfers are two references related to what golfers call the "yips,"[87,88] an involuntary jerk, spasm, or freezing of hand and arm movement during the putting stroke, with disastrous golf results. One article argued against the affliction being a primary anxiety disorder,[87] while another article supported the belief that the "yips" represents a focal dystonia with shared features of other occupational dystonias.[88]

Illness and Injury in Golf

Numerous references of illness and injury in golf exist, including cardiovascular, neurologic, ophthalmologic, orthopedic, infectious, soft tissue, and psychiatric pathology.

In a study of 30 patients suffering a myocardial infarction during recreational sport participation, 12 (40%) occurred during golf.[89] In fact, golf is the most common recreational sport being played when a death occurs.[90] The reason is the underlying, preexisting coronary artery disease in the golfing population, which tends to be male and older. At least one death has been recorded in an 18-year-old patient who was struck across the chest with a golf putter.[91] At autopsy, the heart had multiple internal ruptures. Numerous vascular injuries have occurred from golf, including internal jugular thrombosis,[92] deep femoral artery pseudoaneurysm,[93] vertebral artery dissection causing Wallenberg syndrome,[94] and main pulmonary artery lacera-

tion from a golf swing.[95] Golf syncope has been described in a patient and attributed to a dramatic vagal response from the right carotid sinus triggered by golf swings.[96]

Neurologic illnesses related to golf tend to involve accidental head injury. The two major mechanisms are getting hit with a golf club or golf ball. Lindsay et al., in a study of 1,900 sport-related head injuries, determined that golf was one of the most common sports causing serious head injury.[97] In this study, all of the golfing injuries were compound, depressed skull fractures. A common scenario for neurologic injury is when an individual is struck in the head with a golf club by another player warming up with practice swings on the first tee.[98] Additional references include intracerebral hematoma,[99,100] extradural hematoma,[101] and skull fractures.[97] A "golf improver set" was responsible for two significant intracranial events.[100] These improver sets consisted of a regular golf ball, tethered to a cord with an elastic component that provided a mechanism of inadvertent rebound of the ball into the head of the user. Data from the Lindsay et al. study[97] provided the impetus for the Rule Book of the Royal and Ancient Club of St. Andrews and the U.S. Golf Association[102] to include a warning on the dangers of being hit by a club or ball.[98] Special mention should be made of serious head injury in children, as many of the patients suffering neurologic injury from golf are less than 16.[97,103-105] Other neurologic pathology include long thoracic nerve neuropathy with a winged scapula,[106] and ulnar nerve neuropathy caused by hypertrophy of the flexor carpi ulnaris in a teaching golf professional.[107]

The medical literature related to ocular illness or injury is substantial. The common mechanisms of injury are getting hit in the eye with a golf ball or club,[108-111] resulting in a high enucleation rate for ocular injury.[108] Another common mechanism for injury frequently cited in the medical literature is explosion of liquid-center golf balls.[112-123] Certain golf balls have a liquid center under 2,000-2,500 pounds per square inch of pressure.[118,121] Substances found at the center of liquid golf balls include barium salts, zinc sulfide, gelatin, silicone, sulfuric acid, sodium hydroxide, lead, ethylene glycol, caustic soda, and zinc chloride.[116,122] The most common scenario is a child cutting up a golf ball that has a liquid center under pressure. Barium sulfate is sometimes found in this liquid and can cause conjunctivitis and granuloma formation.[116,123] Some liquid-center golf balls also have alkaline centers that can cause injury.[112] One case reported a child falling onto a spear tipped with a wooden golf tee, causing penetrating ocular injury.[124] In this report, a wooden golf tee penetrated into the optic canal, where both computed tomography and surgical exploration failed to locate it. Although magnetic resonance imaging (MRI) diagnosed the foreign body, panophthalmitis led to enucleation.

Golf's Presence in the Medical Specialties

Golf has a presence in many medical specialties. Medicine has borrowed terms, technologies, even descriptions of procedures, from the game. Following are several examples.

Anesthesiology

- Golf club tubes are used to hold both clean and spoiled fiberoptic scopes.[1]
- The expression "to carry a full set of clubs" means anesthesiologists have all the equipment they need at their immediate disposal in the operating room. Likewise, "replace your divots" means that anesthesiologists should take care of the operating room equipment and clean up after themselves.[2]

Cardiology

- The course of a catheter over the tricuspid valve in order to electrically record from the bundle of His has been described as golf club-shaped.[3]
- Sudden death has been reported after a stenotic mitral valve is occluded by an atrial ball thrombus and named "hole in one sudden death" because of the similarity to a golf ball in a hole.[4]
- Golf is considered one of the best sports for coronary patients.[5]
- In determining the likely placing queue for coronary surgery, one study used a retired golfer as one of three hypothetical patients. The golfer placed last behind the disabled laborer and the civil servant.[6]
- An analogy has been made between physicians and golfers, suggesting that both are better than their past counterparts. Present-day physicians have improved diagnostic and therapeutic technology, and today's golfers have improved natural physiologic and anatomic powers.[7,8]

Emergency medicine

- A review of 10 years of medical coverage at the British Open Championship revealed that the average consultation rate was one in 200 of those attending, of which 3% required hospitalization. The consultation rate at a U.S. Southern Open Golf Championship was one in 130 attendees, with one of these patients hospitalized.[9,10]
- A modified golf cart at California State College at Los Angeles provided transportation for medical services where ambulances cannot travel.[11]

Pathology

- The size and appearance of a golf ball is frequently

Several infectious illnesses have been linked to golf. Golfers living in a retirement community were shown to be at increased risk for Erlichiosis.[125] Less talented golfers, i.e., those who more frequently hit their golf balls into the woods, were at greatest risk. Mycobacterium ulcerans[126,127] and malaria[128] are two infectious risks golfers face.

Numerous orthopedic injuries occur as a result of golf. Two injuries commonly cited in the medical literature are stress rib fractures[129-135] and fracture of the hook of the hamate.[136-142] The complications from undiagnosed hook of hamate fractures are nonunion, rupture of the flexor tendons of the little finger, and ulnar nerve paraesthesia or numbness.[137] The diagnosis is often missed initially; in one study, the mean interval of time between injury and diagnosis was 5.8 months.[137] Patients with this injury will have pain or palpation on the palmar aspect directly over the hook of the hamate. A radiographic profile view of the carpal tunnel as well as computerized tomography have been recommended as the diagnostic procedures of choice.[137,141] For successful management, surgeons frequently need to excise the fracture fragment.[137,140,141] Additional golf-related fractures are acromion,[143] tibial,[144,145] vertebral,[146] spinous process,[147] and patella.[148,149] Other common orthopedic injuries are rotator cuff tears,[150,151] and herniated thoracic disc producing Lhermitte's symptom.[152] Two studies found no association between golf and prolapsed cervical[153] and lumbar disks.[153,154] In fact, the relative risk ratio was actually lower for golf, suggesting a protective effect.[153] Another study did suggest a relationship between golf and acute herniated lumbar discs.[155] Medial epicondylitis[156-159] is a well-cited golf injury. One study also describes injury to the flexor carpi ulnaris.[160]

Soft-tissue injury has been reported from exploding liquid-center golf balls resulting in blast and injection injury to fingers.[161,162] In a case report, a graphite golf club granuloma resulted after a player broke a club over his thigh after a bad shot.[163] This patient developed a painful draining sinus at the site of injury two months after the original wound had healed. Another study details the accidental injection of "white spirit" into the hand of golfers attempting to remove the grip of their golf club in order to replace it.[164]

A variety of miscellaneous golf-related illnesses and injuries have been documented, including golfers' nails, which appear as splinter hemorrhages,[165] lightning strikes,[166] a myriad of dermatologic diseases,[167] and aspiration of golf tees.[168] In contrast to other athletic endeavors among elite, nulliparous athletes, urinary incontinence during golf was not found.[169] In a study of 33 patients injured by a golf club, only one was injured while on a golf course.[103] A one-year survey of sports injuries at a large high school found no significant injuries related to golf;[170] an 11-year study of intercollegiate golf ath-

used to describe the pathologic, histologic, and anatomical findings in disease.[12-20]

Psychiatry

• One book presents the essentials for developing a state hospital golf course and argues that the resulting beautiful environment improves patient care.[21]

• A psychotherapist has found similarities in the situational challenges and coping operations in psychotherapy and golf. "Both situations are tension-filled and allow for minimal motoric discharge ... both escape complete understanding as to the determinants of success or failure of the undertaking ... both are filled with continuous searching self-examination ... both are done in personal isolation with much internal dialogue ... and both are associated with desperate ever shifting efforts to master the almost metaphysical relationship between cause and effect using theory construction in psychotherapy and in the golf swing."[22]

Radiology

• An April Fools' Day article describes patient-performed procedures (PPPs), including barium enema, cervical puncture for myelography, knee arthrography, and ultrasound-guided liver biopsies, thereby freeing the radiologist for "more critical maneuvers," including perfection of the golf swing.[23]

Rheumatology

• An os calcis lesion has been described as shaped like the head of a golf putter.[24]

• A physician was able to assess the status of a patient's giant cell arteritis by charting and plotting his golf scores.[25]

Surgical specialties

• Vocal cord polyps have been described as being golf ball-shaped.[26]

• An innovative technique in orthopedics uses a golf club-shaped instrument for pinning intra-articular fractures of the interphalangeal joints.[27]

• Selecting a surgical chair with a committee of nonsurgeons has been likened to playing golf with matchsticks.[28]

• Urology literature includes several articles describing abnormal "golf hole-shaped" orifices of the entrance of the ureters into the bladder that are highly associated with vesicoureteral reflux.[29-35]

–DDB

letes also found no fractures or refractures.[171]

In an article detailing identification marks for various sports, the specific marks for golfers are hypercallosity of the first finger of the left hand, the palmar and hypothenar areas of the right hand, and the right third finger.[172] This same article relates golfers' bilateral "housemaid's knee" to prayer. Several studies state that many of the injuries in golf are caused by overuse syndrome,[173] inadequate warmup, or improper technique.[174-177] Although their illnesses were not directly a result of playing golf, members of a Glascow Golf Club reported a food-borne outbreak of Hepatitis A.[178] One patient with an anterior cerebral artery occlusion had several visual hallucinations, including seeing a famous professional golfer in his room for three weeks.[179]

Finally, golf has been described by a prominent psychiatrist as a "pecuniary type of sado-masochism with origins in Scotland."[5]

Environment

A number of articles have addressed the use of pesticides and insecticides for golf course management as a potential environmental and health hazard.[180-189] The use of pesticides has resulted in mercury contamination of golf course soils and possibly nearby aquatic ecosystems.[180] Health hazards specifically mentioned include poisoning of geese and wigeon,[181,183,186] increase in non-Hodgkin's lymphoma,[185] and increasing insecticide tolerance leading to mosquito resistance as a result of pesticide runoff from Florida golf courses.[187]

Artificial ponds and lakes on golf courses are ideal habitats for various chironomid species, and large numbers of adult midges emerging from these waters pose nuisance and economic problems.[190] However, the building of one golf course has had a beneficial effect.[191] Builders converted a previously cultivated river bottom into a course, virtually eliminating the presence of snails infected with schistosomiasis.

Physical Disability

Golf is a difficult sport to learn and play. For people with significant physical disabilities, the difficulties are magnified. Numerous articles in the medical literature deal with methods by which people with a disability can play and enjoy the game of golf.

People with upper- and lower-extremity amputations can play golf using several adaptive devices.[192-194] England and Scotland hold annual championships for one-armed golfers.[194] The author has personal knowledge of a young woman with an upper-extremity amputation who used an adaptive golf device to win her local golf club women's championship on a difficult and challenging course (rating 74.7, slope 133).

An adaptive device for a quadriplegic patient has enabled him to play on a par 3 course.[195] Golfers who have undergone total knee and hip arthroplasty can play golf with only mild pain during or after a round.[196-198] Unfortunately, a significant rise in handicap (+4.6 strokes) seems to occur following such procedures.[196,197]

Individuals with damaged knees have effectively used the helicoid knee brace for golfing,[199] and patients who have had an Achilles tendon repaired can play golf using a foot-ankle orthosis for extended ambulation.[200]

Golfers with pathologic conditions of the forearm, wrist, and hand, such as arthritis and tendinitis, can benefit from the use of a new handle design called the BioCurve,[201] which increases comfort, improves the grip, and decreases the transmission of shock. However, use of the BioCurve probably would violate USGA rules.[202]

One study documented the return to sporting activities, golf included, of younger patients who underwent pacemaker placement.[203] In this series of 36 patients, 20 noted no change in their ability to return to sports, and 10 noted improvement in their physical capabilities. Six patients reported that their pleasure in the sport was diminished because they feared damaging the battery.

Individuals with significant eyesight problems, including total blindness, can play golf.[194] One article, "The Eyes of Woodrow Wilson," describes the former president's visual problems, including how they affected his golf game.[204] After suffering what was probably a retinal vein occlusion of his left eye, President Wilson returned several years later to the game and found it was still enjoyable.

One professional golfer has been described as having a variant benign essential tremor, which manifested itself only when beginning a backswing.[205] The tremor in this patient did not respond to propranolol.

One humorous article describes a revised scoring system using letters of the alphabet instead of numbers.[206] This scoring could be used by older golfers as their skills deteriorate, so their score card is less ego-bruising and more esthetically pleasing.

Medical Research and Golf

Plastic, perforated golf balls have been used in research for in vivo polyclonal antibody production,[207-209] in vivo studies of bacteria,[210,211] and in vivo study of inflammatory exudates.[212,213]

One study applied statistical analysis of reliability estimation using trials-to-criterion and sequential-probability-ratio testing with data from a golf chipping test given to 100 beginning golfers.[214] Finally, teaching nursing theory has been compared to a walk on the golf course.[215]

Conclusion

Whether a metaphysical or physiologic event, the game of golf has affected medical practitioners for centuries. Medical literature pertaining to golf is extensive. While sometimes anecdotal and often humorous, it reveals a strong tie between physicians' work and play and reflects a wide range of knowledge helpful in treating people with golf-related injuries. MM

Douglas Brunette is senior associate physician at Hennepin County Medical Center and associate professor in the program of Emergency Medicine at the University of Minnesota Medical School.

References are available upon request by contacting us by mail at *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; by phone at 612/362-3743; or by e-mail at mm@mnmed.org.

South Dakota
Room to Grow

Just imagine...the luxury of outdoor life in a traditional practice in Mitchell, South Dakota. The clinic is seeking a fifth BC/BE FP with OB. Quality family life, low crime rate...and **No State Income Tax!** Above national average compensation and comprehensive benefit package. Call today! Or send your CV to Pam Martin, Business Manager, Mitchell Clinic, 818 W. Havens, Mitchell, SD, 57301. 1-605-996-7772



Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142

E-Mail: stephanie.l.jussila@qm.healthpartners.com



Central Minnesota Group Health Plan

HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220

Continuing Medical Education

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

JUNE, 1997

19 MINIMALLY INVASIVE CARDIAC SURGERY
Presented by: Minneapolis Heart Institute Found.
Location: Hyatt Regency Hotel, Minneapolis

AUGUST, 1997

9 ADVANCED PHACOEMULSIFICATION TECHNIQUES
Presented by: Phillips Eye Institute
Location: Phillips Eye Institute, Minneapolis

SEPTEMBER, 1997

19 MIDWEST GLAUCOMA SYMPOSIUM
Presented by: Phillips Eye Institute
Location: Marriott Hotel - City Center, Minneapolis

26 PAIN DISSEMINATION CONFERENCE
Presented by: Allina Health System
Location: Radison Hotel South & Plaza Hotel, Bloomington

OCTOBER, 1997

15 SUDDEN DEATH & ATHLETES
Presented by: Minneapolis Heart Institute Foundation
Location: Hyatt Regency Hotel, Minneapolis

17 ADVANCED LIFE SUPPORT IN OBSTETRICS (ALSO)
Presented by: Allina Health System
Location: United Hospital, St. Paul

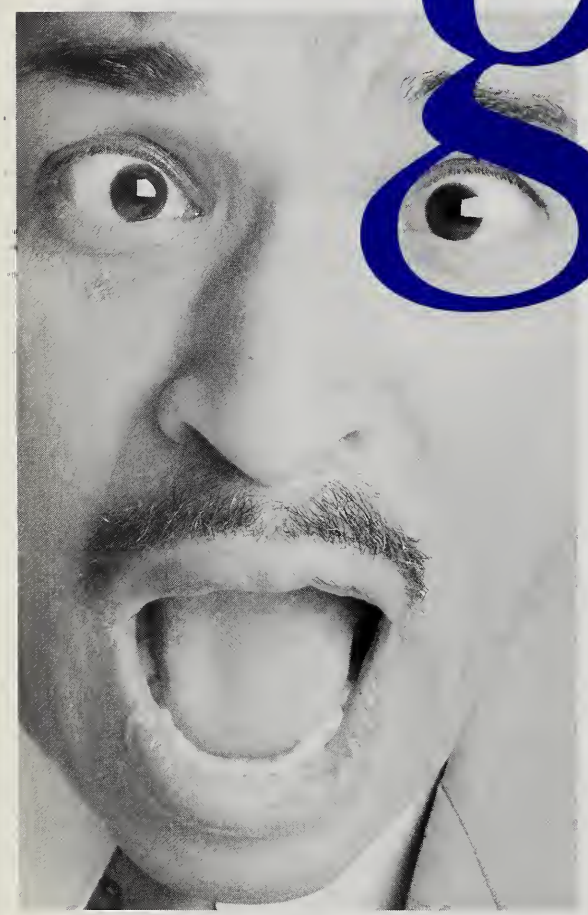
For more information, contact
Allina Clinical Education - (612) 992-2424

™ A Trademark of Allina Health System

Visit the Allina CME calendar on our Home Page at http://www.allina.com

OFFICE PRODUCTS AT PRICES THAT WILL MAKE YOU *gasp*

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED



We all need office supplies. The key is to find the vendor that carries everything you need at the best possible prices. MMBR has selected Office Depot as our endorsed office supply vendor. Through MMBR, you can save an average of *40 percent off* all general office supplies and furniture. MMBR has also arranged retail store pricing on *electronics, business machines, and software,* a special *Purchasing Card* to take advantage of volume discounts at 7 Twin Cities retail stores, and additional *frequent buyer discounts.* Ask about our *convenient billing options.* MMBR can put the immediate response of *Internet* and specialized software ordering at your fingertips, and *next day delivery* is standard with nearly all products. For personal attention and unparalleled service, call 623-2860, or toll free 800-298-MMBR (6627), and ask for our office supply program.

MMBR

OFFICE SUPPLY

MINNESOTA MEDICAL BUSINESS RESOURCES
OWNED BY MMA & HMS

The Monitor
NEWS FOR MINNESOTA PHYSICIANS

ANNOUNCEMENTS

OFFICER NOMINATIONS

The MMA Nominating Committee is beginning the process of nominating candidates for the MMA offices of president-elect, vice president, secretary, treasurer, speaker of the MMA House of Delegates, and vice-speaker of the House of Delegates. If you are interested in running for election as an MMA officer, or if you would like to nominate another MMA member, please contact your representative on the Nominating Committee. Elections will be held at the 1997 MMA Annual Meeting September 14-16 in Brainerd.

The members of the Nominating Committee are: Michael J. Murray, M.D., chair; John R. Balfanz, M.D., East Metro; Nicholas Bernier, M.D., North Central; Paul Sanford, M.D., Northeast; Knute Thorsgard, M.D., Northwest; Barbara Yawn, M.D., Southeast; Elton Wing, M.D., Southwest; and Gary Hanovich, M.D., West Metro.

• • •

AWARD NOMINATIONS

The MMA will present several awards during the 1997 MMA Annual Meeting in September.

The MMA Physician Communicator Award goes to a physician who has shown "exemplary skills" in communicating with the public. The deadline for nominations is July 1, 1997. If you would like to submit a nomination, call Lorrie Holmgren at 612/378-1875 or 800/DIAL-MMA (342-5662).

The Community Service Award honors an MMA physician who has an outstanding record of community service. You will find a nomination form in the May issue of *The Monitor In Brief*. The deadline for nominations is July 7, 1997. If you have any questions, call Karen Tourdot at 612/378-1875 or 800/DIAL-MMA (342-5662).

Provider Tax Is Reduced, $400 Surcharge Repealed

In a stunning victory, the Minnesota Medical Association achieved its No. 1 priority for the 1997 legislative session—convincing legislators to reduce the 2 percent tax and repeal the $400 surcharge on physicians' medical licenses. The House of Representatives had voted to reduce the tax to 1 percent, but Gov. Arne Carlson made it clear that the greatest reduction he would accept was 0.5 percent. "In this political climate, the conference committee report came out better than we could have expected," said Paul Matson, M.D., chair of the MMA Committee on Legislation.

The MMA distributed a letter on the House and Senate floors, urging lawmakers to pass the conference committee report on the MinnesotaCare bill, S.F. 1208. "The MMA has always contended that the MinnesotaCare program should be supported by a broad-based funding source rather than the provider tax," MMA President Raymond Christensen, M.D., wrote. "We are very pleased to see this tax reduction. Minnesota physicians strongly support the provision in the MinnesotaCare bill that will repeal the $400 on physicians' medical licenses. The surcharge is an inappropriate way to increase funding for the Medical Assistance program."

The conference report passed the House and Senate by overwhelming margins.

The tax decrease to 1.5 percent is effective for two years. The tax will remain at 1.5 percent for an additional two years if, in the year 2001, there is a yearly surplus in the Health Care Access Fund. The MMA will strive to make the reduction permanent and to replace the provider tax with other more appropriate funding sources, according to David Renner, MMA director of policy and legislation.

The MinnesotaCare bill also improves access to affordable health care by expanding eligibility for the MinnesotaCare program to 175 percent of the federal poverty level for adults without children, which is $13,800 annual income for an individual.

In other provisions, the MinnesotaCare bill will:

- Create a $150 million reserve fund within the Health Care Access Fund to prepare for possible changes in federal funding.
- Establish a drug purchasing program for enrollees in the Medicare A and B programs who earn up to 120 percent of the federal poverty level and have no supplemental insurance.
- Create up to five pilot projects that would allow small employers to organize health care purchasing alliances to buy health insurance for their employees and allow providers to form networks and contract directly with the alliances. This provision, which was promoted by Advocates for Marketplace Options for Mainstreet (AMOM), is consistent with MMA policy supporting many different options for providers to form physician-sponsored organizations.
- Provide adult, non-preventive dental care with a 50 percent copay.

Provider Tax continued on page 35



Viewpoint

Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

MMA Is a Powerful Voice for Minnesota Physicians

Our success at the Capitol this legislative session clearly showed how important it is for us and for our patients to have the Minnesota Medical Association advocating on our behalf. Only the MMA could have achieved a 0.5 percent reduction of the 2 percent tax and a repeal of the $400 surcharge.

Against overwhelming odds, the MMA convinced legislators that these unfair taxes should be reduced. How did we do it? With the help of strong grassroots support from our members. When the MMA sent out an urgent appeal, asking members to call the governor and their legislators about the tax, the response was phenomenal. Calls and letters poured in. This support for our lobbying effort is extremely important. Legislators listen to their constituents.

Another reason for our success was the MMA's growing visibility and credibility at the Minnesota Legislature. This is no accident. In the past few years, the MMA has worked hard to improve its ability to unite for a common goal, develop sound public policy positions, set reasonable expectations, and achieve legislative victories.

We adjust our expectations to the current political climate. Ultimately, our goal is to replace the 2 percent tax with a broad-based funding source, but the governor made it clear that the greatest reduction he would accept was 0.5 percent. Given this political reality, the MMA achieved the greatest tax reduction possible.

The MMA has won respect at the Minnesota Legislature and in the community for its commitment to the goal of health care coverage for all Minnesotans and for its focus on core values, such as patient advocacy and justice.

This session, we stressed our continuing support for the MinnesotaCare program and made it clear that we wanted to change the funding source, not undermine the program.

The MinnesotaCare program works. Welfare costs drop as people move off public assistance programs, take jobs, and buy insurance on a sliding scale. People with insurance coverage are more likely to go to a physician for preventive care. More children get the immunizations they need.

MMA policy supports expansion of eligibility for the MinnesotaCare program. We assured lawmakers that the growing surplus in the Health Care Access Fund would allow the state to increase eligibility and at the same time reduce the 2 percent tax. Currently, there is a $419 million surplus in the Health Care Access Fund. The MinnesotaCare bill not only cuts the provider tax but also increases eligibility for people without children to 175 percent of the federal poverty level, which is $13,808 annual income for individuals and $18,568 for couples.

In opposing the 2 percent tax, the MMA raised the issue of fairness. Practicing in a teaching hospital, I am sometimes called upon to lecture medical students and residents on medical ethics. I tell them that among the core values that distinguish the medical profession are altruism, patient advocacy, integrity, and justice.

Perhaps our profession's commitment to justice is why the unfairness of the 2 percent tax and the $400 surcharge seems such an affront. We resent being singled out to pay for a state program that deserves the support of all Minnesota taxpayers. Ever since legislators began discussing ways to reduce the number of people who are uninsured, the MMA insisted there should be an adequate, broad-based funding source dedicated to ensuring universal health care coverage. This was one of our eight principles of health care reform developed in 1991, and it continues to reflect our position. The narrow provider tax does not meet our standard of fairness.

We can be proud of our achievements at the Legislature. In addition to our victory with the MinnesotaCare bill, we convinced legislators to repeal the growth limit for providers, extend the exclusive contract ban, and pass a strong bill to prevent adolescents from buying tobacco. As *The Monitor* goes to press, many of these bills are on the governor's desk.

I would like to thank all of you who wrote letters, called your legislators, and testified at the Legislature. I would also like to thank MMA staff for their outstanding efforts on our behalf.

This session, the MMA achieved its highest priorities while maintaining integrity, seeking our patients' well-being, and upholding high standards. We did not compromise our core beliefs regarding health reform and patient advocacy. • • • • •

Provider Tax *continued from page 33*

• Increase reimbursement for dental care by 15 percent.

• Repeal the $10,000 inpatient cap for families with children that have annual incomes up to 175 percent of the federal poverty level.

The conference committee removed any-willing-provider provisions for chiropractors and for hospitals and clinics in communities with fewer than 25,000 people and an exemption from paying the provider tax for dentists. • • • • •

Growth Limits Are Repealed

The governor has signed into law a bill repealing the growth limits for health care providers and replacing the growth limits for health plans with cost containment goals. Repeal of the growth limits was one of the MMA's top priorities this session. • • • • •

Patient Protection Bill Extends Exclusive Contract Ban

The Patient Protection Bill, S.F. 960, passed and is awaiting the governor's signature as *The Monitor* goes to press. This legislation will reinstate the ban on exclusive contracts between health care providers and health plans or other providers, which sunset on January 1, 1997. This is a victory for the MMA, which has worked closely with the Minnesota Medical Group Managers Association and others to reinstate the ban and thus protect providers from being pressured into signing exclusive contracts.

The Patient Protection Bill also includes many provisions similar to those developed by the AMA in its Patient Protection Bill. The bill will:

• prohibit providers from signing gag clauses;

• prevent health plans from retaliating against a provider for disclosing information about health plan coverage or for criticizing the plan;

• require health plans to disclose general information about their financial arrangements with providers;

• require health plans to report the five highest salaries they pay;

• require health plans to establish procedures to ensure that patients have continuity of care if they are forced to change plans;

• require health plans to authorize standing referrals to non-primary care specialists for enrollees who have chronic conditions;

• set up a consumer assistance office to help with coverage questions;

• require health plans to cover emergency care outside the network and outside the service area; and

• require health professionals to wear name tags identifying their profession.

Thanks to MMA efforts, failure to wear a name tag is not an offense that is reportable to the Minnesota Board of Medical Practice. • • • • •

Join an MMA Committee

• • • • • SERVING ON AN MMA committee is an excellent way to keep up-to-date on interesting issues and to voice your concerns and opinions. The MMA benefits greatly from the committee members' generous contributions of time and expertise.

The MMA Committee on Bylaws, Committees and Membership is beginning the process leading to appointment of members of the MMA's standing committees for terms beginning January 1, 1998. The committees are: Accreditation and Continuing Medical Education; Administration and Finance; Bylaws, Committees and Membership; Communications; Ethics and Medical/Legal Affairs; Legislation; Medical Practice and Planning; Minority Affairs; Professional Liability; Public Health and Preventive Medicine; Women Physicians; and Workers' Compensation.

MMA members are eligible to serve on one committee at a time for a maximum of six consecutive years. Committee terms are for two years, except for the Committee on Accreditation and CME, which has three-year terms. Trustee district representation on each committee is based on the total number of members in the district. Most committees meet an average of four times a year.

The committee appointment process begins when each county medical society nominates candidates from its membership to fill vacancies for the upcoming year. Trustees in each district review and submit the slate of nominees to the Committee on Bylaws, Committees and Membership, which nominates candidates for any remaining vacancies and forwards its recommendations to the MMA Board of Trustees for ratification.

In addition, the Hospital Medical Staff Section, the Young Physicians Section, the Resident Physician Section, and the Medical Student Section appoint designated committee members annually to serve on select committees.

To be considered for appointment to a committee, please call your component medical society or call Jane Phillip at the MMA at 612/378-1875 or 800/DIAL MMA (342-5662). She can also give you more information about the activities of each committee and about the appointment process.

LEGISLATIVE NEWS

MERC Receives Funding

A provision included in the Omnibus Health and Human Services Appropriation Bill provides significant funding for the Medical Education and Research Cost (MERC) committee. For the biennium ending June 30, 1999, the state will provide $5 million from the General Fund and $3.5 million from the Health Care Access Fund, which will be matched with federal Medical Assistance money, for a total appropriation of more than $17 million. Next biennium, this increases to more than $34 million.

The money will be used to train physicians, nurses, physician assistants, pharmacists, and other health care personnel. In addition, the Department of Human Services will begin developing a formula to ensure that a portion of the payments made to health plans in the Medical Assistance program will be redistributed to the MERC account.

For two years the MERC committee has been trying to find a way to ensure continued funding for medical education and research in the competitive Minnesota market place. As pressure to contain health care costs mounts, insurance and public program reimbursements can no longer pay for the cost of training and research.

Immunization Registry Bill Died

The Minnesota Department of Health (MDH) proposal to create a statewide immunization registry died this session because of opposition to sharing immunization data without parental consent. The MMA supported this legislation as a way to improve the state's tracking of immunizations and to help raise the overall immunization rate for children. Opposition was partially based on fear the government would acquire too much medical data on citizens and fear of potential abuse of the data. MDH intends to pursue the concept of an immunization registry again next year.

Lower Alcohol Level Is Defeated

The conference committee on the DWI bill, S.F. 77-Marty, rejected both the House and Senate proposals to lower the blood alcohol level needed to trigger a DWI offense. The House bill would have lowered the blood alcohol limit from 0.1 to 0.08 for drivers older than 19 and to 0.04 for drivers younger than 19. The Senate bill would only have applied to repeat offenders. This legislation to tighten Minnesota's drunk driving laws was spearheaded by Mothers Against Drunk Driving and supported by the Minnesota Medical Association. The conference report does call for stiffer penalties and mandatory alcohol monitoring for drivers whose blood alcohol level is higher than 0.2 percent.

Requirement for ER Reports Is Removed

A provision was deleted from the Omnibus DWI Bill that would have required health care providers to report to law enforcement agencies automobile accident victims who the provider knew, or had reason to know, had been drinking alcohol. The Minnesota Medical Association, working with the Minnesota Hospital and Healthcare Partnership, succeeded in eliminating this provision on the Senate floor over the objections of the bill's authors. The MMA opposed this provision because of a concern that accident victims might forgo treatment if they feared being reported to the police. The MMA does not think health care providers should be forced to become law enforcement officers. The House author removed this provision from the bill after the MMA and MHHP raised these concerns.

Stop the Violence Day at the Dome



Raymond G. Christensen, M.D., MMA president, addressed the crowd at the Second Annual Stop the Violence Day at the Dome.

Announcements

Attend the Public Health Forum

You are invited to attend an all-day conference on collaborative efforts between medicine and public health in Minnesota, presented by the Minnesota Medical Association, the Public Health Association, and the Center for Population Health. The conference will be held on Friday, June 13, at the Earle Brown Heritage Center in Brooklyn Center. The keynote speaker is Philip Lee, M.D., the recently retired assistant secretary for the U.S. Department of Health and Human Services. The conference, which is funded by a Robert Woods Johnson grant, will build on the American Medical Association/American Public Health Association "Medicine/Public Health Initiative." For more information, call Janet Silversmith at 612/378-1875 or 800/DIAL-MMA (342-5662).

OIG Announces Medicare Anti-Kickback Guidelines

The Office of the U.S. Inspector General (OIG) recently issued guidance for seeking advisory opinions on whether proposed transactions will pass muster under anti-kickback provisions. The Kennedy-Kassebaum Act includes a provision requiring the OIG to establish a method to issue advisory opinions to health care providers who want to set up networks that comply with anti-kickback provisions. For more information, call Patricia Franklin, J.D., at 612/378-1875, or 800/DIAL-MMA (342-5662).

Strong Tobacco Licensing Bill Awaits Governor's Action

Despite fierce tobacco industry pressure, the House and Senate passed a strong bill to reduce illegal sales of tobacco to children. As *The Monitor* goes to press, Gov. Carlson has not decided whether he will sign this bill, H.F. 117, which is the culmination of eight years of attempts by antismoking advocates to pass legislation to prevent Minnesota children from illegally buying tobacco.

The MMA and other members of the Smoke-Free Coalition are strongly urging Gov. Carlson to sign H.F. 117. A letter from Raymond G. Christensen, M.D., MMA president, states, "This bill strikes a fair balance between the concerns of retailers and the intent of the MMA and other tobacco-control advocates to prevent children from becoming addicted to tobacco."

The bill would:

- License all retail outlets that sell tobacco.
- Set fines for employees who sell tobacco to young people under age 18.
- Set a penalty of a 90-day driver's license suspension for a minor caught using a fake identification to buy tobacco or an adult who lends identification to a minor to purchase tobacco.
- Require one compliance check a year by local law enforcement agencies.
- Ban self-service displays of single cigarette packs unless the store is limited to adults over age 18.
- Require tobacco companies to report to the commissioner of commerce if traces of the following five toxins are present in the tobacco product: ammonia, cadmium, lead, arsenic, and formaldehyde.

A provision that would have required the disclosure of "slotting fees" paid by tobacco companies to retailers for preferential placement of the product within the store was not included in the final compromise bill.

After the compromise bill emerged from conference committee, tobacco industry lobbyists descended on the Capitol and tried to weaken or kill the bill by sending it back to conference. They focused their most bitter opposition on a provision calling for ingredient disclosure, which had been amended to the bill on the Senate floor. In a substantial compromise, the conference committee scaled back the original amendment asking for disclosure of more than 1,000 toxic substances to five. In his letter to the governor, Christensen wrote, "If people are to make informed decisions about whether to smoke, they should know what toxic substances are in tobacco products."

Tobacco industry lobbyists also opposed the required compliance check and the ban on self-service for single packs of cigarettes. According to the Smoke-Free Coalition, a ban on self-service of single packs is one of the most effective ways to reduce illegal sales of tobacco to teenagers.

As pressure mounted, the MMA issued an urgent alert to members of the Legislative Network, urging them to encourage their legislators to hold firm. The House passed the conference report May 15, and the Senate followed suit on May 19.

The MMA continues to urge the governor to sign H.F. 117 and protect the health of Minnesota children.

E-Mail the MMA

You can send E-mail directly to MMA staff. The E-mail address is: the initial of the person's first name, the last name, followed by @mnmed.org

For example, the E-mail address for the editor of *The Monitor* is:

lholmgren@mnmed.org

The E-mail address of the MMA is mma@mnmed.org

MMA Assesses Flood Damage

The floods that swept through Minnesota disrupted health care and drove thousands of people from their homes, but fortunately early fears of widespread destruction of medical clinics and equipment seem to be unfounded.

The Minnesota Medical Association worked with the Office of Rural Health at the Minnesota Department of Health to identify Minnesota clinics that were damaged by floods and needed help restoring medical services to their community. After making phone calls to clinics throughout the flooded area, MMA and MDH staff believe that the Bridges Medical Services Clinic in Ada is the only clinic in Minnesota to suffer structural damage from the flood. Other clinics were forced to close for several days because flood waters made them inaccessible to patients and employees.

Darrell Carter, M.D., of Granite Falls called the experience a "nightmare." City planners had prepared for the worst, but the water rose five feet higher than their projections. Thousands of people worked together for four days, piling 600,000 sandbags on the dike. "It was a struggle of the community against nature," Carter said. "No one quit. Even little kids were still working at 4 a.m. Our community is stronger after this experience." As the water continued to rise, Carter and others at the Granite Falls Clinic prepared to load medical equipment, records, charts, and computers on a truck if necessary. "Flood waters nearly broke through; if the river had risen one more foot our clinic would have been inundated, but as it was, we escaped unscathed," Carter said.

Raymond G. Christensen, M.D., MMA president, said, "The MMA is very concerned about our colleagues who—in the face of terrible personal losses—continue to care for their patients."

Flood Damage continued on page 40

MMA Sets Up Flood Relief Fund to Help Clinic in Ada

The town of Ada, which was under water a few weeks ago, seems to be almost back to normal. Flood waters have receded, people are cleaning out their homes, farmers are beginning to hope for rain.

It will be a long time, however, before full health care services are restored. Flood waters devastated the Bridges Medical Center, a city-owned health care facility in this community of about 1,700 people. The Federal Emergency Management Agency (FEMA) will provide money to repair but not to replace the facility, which includes a hospital, clinic, and nursing home. Kyle Rasmussen, clinic manager, says it is not feasible to repair the severely damaged buildings. He estimates that $3.5 million will be needed in addition to the funding from FEMA.

The clinic was hit hardest, according to Rasmussen. The floor, coated with mud and sludge, is buckling. Cracks split the foundation and run along the weight-bearing walls. "If someone inside the clinic turns on a flashlight, you can see it from outside, light shining all along the cracks," said Rasmussen.

Plans call for a temporary modular clinic/hospital to be erected in about two months. Meanwhile, patients receive their health care in one exam room in a Winnebago trailer. "I pray no major trauma will happen," said Rasmussen. "People realize now how terrible it is to be without a hospital and clinic. So far no one has had a heart attack, but something's bound to happen." The emergency 911 ambulance service is still operating, but the nearest hospital that can stabilize a patient is 50 miles away in Fargo, said Rasmussen.

The MMA has set up a special fund to help the Bridges Medical Center, which appears to be the only Minnesota clinic to suffer significant flood damage. The MMA Flood Relief Fund has been established through the Minnesota Physicians Foundation. • • • • •

MMA Sets Up Flood Relief Assistance Network on Home Page

The MMA has set up a Flood Relief Assistance Network on its home page to help physicians who are trying to maintain their practice and, at the same time, pump out their basements and restore their flood-ravaged homes. Physicians who visit the MMA home page at www.mnmed.org are invited to press one of two buttons: 1) I need assistance, or 2) I would like to help. The home page will allow physicians to relieve their colleagues in the flood-stricken areas and to make sure people in the flooded areas have ongoing access to health care.

The MMA home page also includes up-to-date flood-related information, including public health information from the Minnesota Department of Health, phone numbers to call to assist in the clean-up effort, and information about ways to contribute financially to rebuilding devastated communities.

The home page notes that MMA employees collected donations to be distributed by the Salvation Army. Donations include bottled water, pop, new rubber gloves, personal hygiene products, baby diapers, cleaning supplies, and brooms. • • • • •

MMA Flood Relief Fund

Help Restore Access to Health Care in Ada

Bridges Medical Center in Ada, Minnesota, was severely damaged by the floods.

Money is needed to rebuild this city-owned health care facility, which is located in a health professional shortage area.

The Minnesota Medical Association has set up a special fund to benefit the Bridges Medical Center, which includes a hospital, nursing home, and clinic. One hundred percent of the contributions from Minnesota's physician community will go directly to restoring health care services to people in this medically underserved area.

"I pray no major trauma will happen. Now we realize how terrible it is to be without a hospital and clinic. So far no one has had a heart attack, but something's bound to happen."

—Kyle Rasmussen, clinic manager

The MMA Flood Relief Fund has been established through the Minnesota Physicians Foundation, a charitable foundation established by and affiliated with the Minnesota Medical Association.

All contributions are tax deductible. Please make checks payable to the Minnesota Physicians Foundation and write "Flood Relief Fund" on the memo line. Send your contribution to 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, Attn: Kimberly Halva.

Name _____

Address _____

MPF also accepts VISA, MasterCard, and Discover.

Card Type _____

Issued to _____

Card # _____

Signature _____ Exp. Date _____

Announcements

MMA/MMIC Offer Early Detection Conference

Failure to diagnose breast cancer has been identified as a leading cause of malpractice claims. Midwest Medical Insurance Company (MMIC) and the Minnesota Medical Association are jointly sponsoring a risk management conference, "Diagnosing Breast Cancer: A Team Approach to Early Detection." The conference will focus on risks of misdiagnosis, proper techniques for screening and evaluation, and the costs of malpractice.

The MMA is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to sponsor continuing medical education for physicians.

The MMA designates this educational activity for a maximum of 2.0 hours in category 1 credit towards the AMA Physician's Recognition Award. Each physician should claim only those hours of credit that he/she actually spent in the educational activity.

The Cornhusker, Lincoln, Nebraska, June 26, 2 p.m. to 5 p.m.

St. Luke's Hospital, Duluth, Minnesota, July 14, 6 p.m. to 9 p.m.

Holiday Inn, Brookings, South Dakota, August 16, 8 a.m. to 11 a.m.

Des Moines Marriott, Des Moines, Iowa, September 13, 8 a.m. to 11 a.m.

The registration fee is $75; there is no charge to physicians insured by MMIC. For more information call Robin Houlihan at MMIC, 612/922-5445 or 800/328-5532.

MMA Encourages Parent Education

As a member of the Coalition for a Violence-Free Society, the MMA participated in a news conference May 5 in St. Paul to announce the release of posters, magnets, and brochures with messages that encourage parents raise their children in a positive, nonviolent way.

"The MMA recognizes violence as one of our most serious public health problems. It is often bred in the home," said Judith Shank, M.D., secretary of the MMA. "The positive parenting materials developed by the Initiative for Violence Free Families and Communities in Ramsey and Hennepin counties will help parents set a nonviolent example for their children. The MMA encourages parents to learn as much as they can to prepare them for the toughest job they'll ever have."

The MMA adopted a resolution at its 1996 Annual Meeting stating that the members of the Minnesota Medical Association will encourage all new parents to participate in parent education classes and that health systems should be encouraged to provide parent education for their clients so that we may raise healthier children and produce a healthier, less violent society.

Flood Damage *continued from page 38*

At the suggestion of the Minnesota Medical Association, the Office of Rural Health and Primary Care is exploring the possibility of providing some funding from the state community health center program to primary care clinics that suffered flood damage or provided uncompensated care. Eligible clinics must be located in a rural shortage area that is medically underserved, a federal health professional shortage area, or a governor-designated shortage area and must be a nonprofit corporation with local resident governance or be a governmental entity.

Staff from the MMA and the Office of Rural Health called clinics in Halstad, Red Lake Falls, Thief River Falls, Crookston, Breckenridge, Fosston, Erskine, Fertile, Benson, Browns Valley, Granite Falls, New Ulm, Hallock, Warren, St. Peter, Montevideo, and Moorhead, as well as the Stearns-Benton Medical Association, and found no structural damage. If you know of any flood-damaged clinics, please call Lorrie Holmgren at 612/378-1875 or 800/DIAL-MMA (342-5662), or E-mail to lholmgren@mnmed.org

Advanced Practice Nursing Report

The 130-page report of the MMA Ad Hoc Task Force on Advanced Practice Nursing is available free to MMA members; there is a nominal charge to nonmembers. Free copies of the four-page Executive Summary are also available. To obtain a copy of the report, call Pat Biersach at 612/378-1875, or 800/DIAL-MMA (342-5662).

The Monitor
JUNE 1997

President
Raymond G. Christensen, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Editor
Lorrie Holmgren

Shaken Baby Syndrome

Diagnosis and Prevention

A thorough understanding of shaken baby syndrome can help physicians diagnose and prevent this deadly form of abuse.

Jane Swenson, M.S., C.P.N.P., and Carolyn Levitt, M.D.

Editor's Note: *Child abuse has been a problem from the beginning of human history. Our definition and our tolerance of child abuse have changed greatly over the last century. Twenty years ago, Carolyn Levitt, M.D., coauthor of this paper, and I sat on a committee to develop child abuse prevention programs in every Minnesota county. We encountered resistance from well-meaning physicians who suggested that we "butt out" and let them handle the situation. Child abuse required a team approach then and still does. None of us alone can deal with child, parent, family, medical, social, and financial problems associated with child abuse. But before anyone can deal with these issues, we must admit the problem exists and learn to identify its victims. This article discusses one of the most deadly child abuse syndromes—shaken baby syndrome (SBS). The subject is unpleasant but must be addressed. Please read and remember what the authors have clearly laid out as the signs, symptoms, and likely outcomes of SBS. Then apply their recommendations for preventing it.*

—Barbara P. Yawn, M.D., M.Sc.,
Series Editor

At least 2,000 children in the United States die from abuse or neglect each year, and another 18,000 are permanently disabled. Most of these children are under age 4. The Centers for Disease Control and Prevention estimates, taking misclassification of child deaths into account, that 11.6 of every 100,000 children age 4 and under die from abuse and neglect annually—more than the nation's murder rate.[1]

This article focuses on shaken baby syndrome (SBS), one deadly form of child abuse. We describe the mechanism of injury, presenting symptoms, the diagnosis, the incidence, a perpetrator profile, and how health care providers can work to prevent SBS.

What Is Shaken Baby Syndrome?

Shaken baby syndrome is a form of abusive head trauma and accounts for an estimated 10% to 12% of all deaths resulting from abuse and neglect. Approximately 25% of all SBS victims die, and 41% are under age 1.[1]

John Caffey, M.D., a pediatric radiologist, was credited in 1972 with recognizing a type of child abuse he called the whiplash shaken infant syndrome (WSIS). Caffey's definition of WSIS describes vigorous manual shaking of infants by the extremities or shoulders, with whiplash-induced intracranial and intraocular bleeding and no external signs of head trauma.[2,3] X-rays of these children often revealed occult metaphyseal fractures of the extremities.

In 1987, research challenged Caffey's definition by suggesting that shaking alone was not enough to cause serious head injuries in infants.[4,5] Researchers argued that impact to the head is a necessary force in causing this syndrome and suggested that "shaken impact syndrome" was a more accurate term.[4] Today, rib fractures and subtle bruises are included in the definition of SBS, but abused children with more obvious head and other injuries fit better into the general battered child syndrome category.

The Mechanism of Injury

Many theories have been offered to explain the mechanisms, or causes, of intracranial and intraocular injuries from SBS. When an infant is shaken, the shaker usually grabs the infant around the thorax, arms, or shoulders and shakes to and fro, causing the infant's head to whip forcibly backward and forward. Some researchers postulate that infants are especially vulnerable to intracranial injuries because their heads are large, with open sutures permitting movement of the cerebral hemispheres; they have weak neck muscles; and the unmyelinated immature brain has a higher water content. Another, less recognized, factor is that a 70 kg adult can exert tremendous force on a 7 kg infant.

Vigorous repetitive shaking produces acceleration and abrupt deceleration of the infant's head, sudden movement of the brain within the skull and dura, and tearing of the bridging veins between the venous sinuses attached to the skull. The result is subdural hematomas,

the hallmark of SBS. In addition, abrupt deceleration, sudden impact, and severe rotational forces may lead to intraparenchymal shearing injury, subarachnoid hemorrhages, diffuse axonal injury, cerebral edema, and hypoxic-ischemic encephalopathy. Apnea may exaggerate this latter finding.

Some researchers believe retinal hemorrhages in SBS victims are related to compression of the infant's thorax or to acute increased intracranial pressure secondary to injury and edema.[6] Others propose that severe tractional forces from the vitreous cause retinoschisis and shearing of intraretinal blood vessels.[6] A few studies question whether CPR may have caused the hemorrhage. They conclude that CPR is unlikely to cause retinal hemorrhages and suggest that even if CPR is administered, retinal hemorrhage should be considered secondary to craniocerebral trauma.[7] Retinal hemorrhages are seen infrequently following accidental head trauma.[8-10] Clinical experience indicates that massive retinal hemorrhages, retinal tears, and vitreous hemorrhages are nearly pathognomonic for child abuse unless a severe, witnessed accidental head injury is documented.

Presenting Symptoms

SBS victims are typically under age 1, with most about 6 months of age.[5] SBS victims present a broad spectrum of symptoms, including respiratory difficulties, vomiting, irritability, listlessness, lethargy, bradycardia, apnea, seizures, poor suck, and poor feeding. Subtle bruises, full or bulging fontanelle, large head circumference, anemia, hypothermia, and rib or metaphyseal fractures may be clues to SBS.[5,11,12] Some children present with vague symptoms mimicking childhood viral illnesses, while others present comatose, apneic, and requiring resuscitation.

As with other forms of child abuse, examining practitioners rarely know whether the child has a history of being shaken. In addition, lack of external evidence of trauma compounds the difficulty of diagnosis.

Diagnosis

Clinicians' ability to suspect and then recognize the often subtle signs and symptoms associated with SBS is crucial for diagnosis. Some SBS infants are never diagnosed because of mild symptoms and poor medical history. Some children are missed because their physicians or nurse practitioners are still unfamiliar with the diagnosis of SBS and don't have access to radiographic equipment.

Physicians should examine carefully for signs of injury in any infant presenting with unexplained lethargy or seizures. Computed tomography (CT) of the head and an opthalmologic examination are particularly helpful. A lumbar puncture yielding bloody or xanthrochromic fluid indicates recent or past trauma. Clotting dysfunction should be assessed initially and followed.

Because CT reveals all injuries requiring urgent intervention, it is the primary tool for evaluating a brain-injured infant. CT can detect subgaleal, epidural, subdural, and subarachnoid hemorrhages, skull fracture, cortical contusions, cerebral edema, midline shifts, as well as chronic lesions, including chronic subdural hematoma, cerebral atrophy, hydrocephalus, and post-traumatic and hypoxic-ischemic encephalopathy. Repeat CT should be used to follow and document the progression of the injuries.

Physicians should use magnetic resonance imaging (MRI) as a complementary study when evaluating children with brain injuries. Both MRI and CT can provide broad, general time frames as to when the injury occurred but are not likely to identify the narrow time frame that is so often needed to connect the injury to a specific perpetrator.

As soon as the infant's medical condition permits, the physician should obtain a skeletal survey, including the long bones, skull, spine, and ribs.[12] A bone scan is particularly helpful in documenting acute rib fractures that may not be detected on the first skeletal survey. Chip or corner fractures of the metaphyses of the long bones may be missed or hidden on bone scans by the increased uptake of normal growing bone in these areas. Skull fractures that are bilateral, multiple, or that cross suture lines are most likely nonaccidental.[13] A skeletal survey may also reveal single or multiple fractures of the shaft or metaphysis of long bones or rib fracture.[14] The survey should be repeated in two weeks to better delineate new fractures that may not be apparent until they heal.

The Incidence of SBS in Minnesota

We have no precise figures on the incidence of SBS in Minnesota or the nation. Instead, we extrapolate from large populations to arrive at a reasonable approximation. From an extensive review of prevalence studies, we conclude that abusive head injury represents 10% to 20% of all physical child abuse injuries; the highest incidence is in children under age 2.[15]

Data showing the number of abused children with life-threatening head injuries admitted to children's hos-

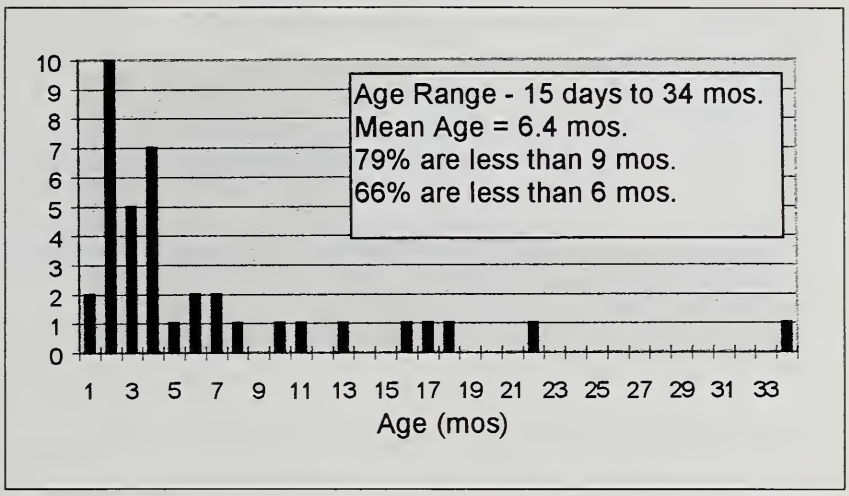
SBS Resources

MIDWEST CHILDREN'S RESOURCE CENTER (MCRC) is a specialty center for child abuse services. A program of Children's Health Care, MCRC brings together a team of specialists who provide services and consultation upon referral from child protection and law enforcement agencies, doctors, therapists, attorneys, and parents. For professional consultation services, please call 612/220-6750 or 800/422-0879 (Minnesota only) or fax 612/220-6770.

SBS PREVENTION MATERIALS (brochures, sixth-grade curricula, and "Portraits of Promise: Preventing SBS" videotapes) can be obtained by contacting Jane Swenson, Midwest Children's Resource Center, 360 Sherman Street, Suite 200, St. Paul, MN 55102; phone 612/22-6703; fax 612/220-6770.

pitals each year are becoming more readily available. Eight children's hospitals with varying years of study and referral patterns report prevalence figures of new abusive head trauma cases ranging from four to nine victims per year.[15] A study by the Children's Hospital in Denver, Colorado, identified 150 cases of abusive head trauma over a 12-year period, an average of 12.6 patients per year.[16]

Staff of the Midwest Children's Resource Center recently completed an eight-year study reviewing all cases of serious head trauma in children under age 3 seen at Children's Health Care–St. Paul. The study documented 38 cases of SBS between 1988 and 1995, ranging from three to seven cases per year. If Children's Health Care–Minneapolis and Hennepin County Medical Center had been included in this study, there would have been at least 120 cases in eight years.



FIGURE—Age range for SBS victims diagnosed at Children's Health Care–St. Paul during eight-year period, 1988-1995.

The purpose of the study conducted by Children's Health Care–St. Paul was to determine whether some presenting features of the characteristic cases of abuse could aid in the diagnosis of SBS. None of the 38 children studied had a history of being shaken. However, all presented with some type of neurologic or cardiorespiratory symptoms. The incidence of SBS was highly dependent on age. The children's ages ranged from 15 days to 34 months, with a mean age of 6.42 months. Sixty-six percent of these children were under 6 months, 79% were under 9 months, and 85% were under 1 year (see the figure).

The study divided the 38 cases into two categories: good and poor outcomes (see the table). Criteria included neurologic outcomes, vision, physical disabilities, and death. Twenty of the infants had good outcomes, including 14 with normal neurologic status, two with impaired vision, and two with seizures. Two of these infants' siblings were also abused. The group with poor outcomes consisted of 18 children, 12 of whom died. Of the 12, two had siblings who suffered recurrent abuse. Among the remaining children were three with severe neurologic dysfunction, two with severe visual abnormalities, and one child who is paraplegic from a cervical cord injury and is ventilator dependent.

Table

Outcomes for 38 SBS victims diagnosed at Children's Health Care–St. Paul, 1988-1995 (ages 15 days to 34 months)

Good outcome (20)	Poor outcome (18)
14 normal neuro status	12 died
2 impaired vision	3 severe neuro dysfunction
2 seizures	2 severe vision abnormality
2 family history of abuse	1 cervical cord injury

The Perpetrators of SBS

Perpetrators don't necessarily fit a clear profile. They range in age from 13 years to 80 years. They are from all cultures, races, and socioeconomic and religious backgrounds. They are male and female. "Crying" is the most common trigger perpetrators cite for shaking a baby. When a baby won't stop crying, perpetrators vent their frustration and anger by shaking the baby they are attempting to comfort. Research shows that 25% to 50% of the American public is unaware of the dangers of shaking a child.[17]

Approximately 70% of SBS victims are shaken by men, according to the Denver Children's Hospital study. Of 127 SBS cases where perpetrators of abusive head trauma could be identified, 68.5% were male and 31.5% were female. Combined, fathers and boyfriends commit more than 60% of these crimes.

The U.S. Advisory Board on Child Abuse and Neglect reports that "the average abusive parent is in his or her mid-20s, lives near or below the poverty level, often has not finished high school, is depressed, unable to cope with stress, and has experienced violence firsthand." The report also reveals that male abusers tend to inflict fatal injuries by beating their victims' head and body, shaking them violently, suffocating or immersing them in scalding water, and other acts.[1] Other risk factors associated with perpetrators of child abuse, and specifically SBS, are isolation, violence in the home, financial difficulties, relationship problems, substance abuse, inadequate knowledge of child development, and a lack of positive or nurturing feelings for the child. ⇨

The Role of Physicians in Preventing SBS

In 1997, the National Center on Child Abuse and Neglect funded a three-year, $600,000 grant to begin or expand SBS prevention efforts in all states. Since then, all states have developed efforts to raise awareness and educate the public about the dangers of shaking children.

In Minnesota, 1996 marked the fifth year of "Awareness, Advice and Advocacy: The Child Abuse Project," a partnership of the Junior League of St. Paul and Midwest Children's Resource Center at Children's Health Care–St. Paul. The goal of the project is to reduce the incidence of SBS through increased public awareness and community education. The public awareness component includes public service announcements, billboards, brochures, transit stop posters, restroom advertisements, and other creative approaches aimed at reaching the general public. The community education component includes an adult curriculum presented to parenting classes, high school students, teen parents, correctional facility inmates, daycare provider groups, and various other community organizations. Sixth-grade students in St. Paul public schools are taught "Fragile: Handle With Care," a curriculum designed to teach soon-to-be babysitters about child development, responsibilities involved when caring for a young child, tools to handle stress, and the dangers of shaking young children. "Portrait of Promise: Preventing SBS," an 11-minute educational videotape produced by the Child Abuse Project and endorsed by the American Academy of Pediatrics, is available in English, Spanish, and Hmong.

All caregivers need to hear the SBS prevention message. Physicians, nurse practitioners, physician assistants, and nurses are in a unique position to inform patients about SBS resources and primary prevention methods. Since a large percentage of SBS perpetrators are male, clinicians need to make a conscious effort to develop approaches and resources that involve male caregivers of pediatric patients. Some possible approaches may include:

- inviting or encouraging the father or other significant male caregiver to attend early well-child visits;
- listening and watching for signs of stress in the parents or other caregivers of new babies and young children; taking time to talk about the stress of 24-hour baby care; recognizing that taking care of a small child is a big job, and affirming that it is a sign of strength to ask for help when needed;
- inquiring about the father's adjustment to fatherhood and caregiving;
- knowing what your community has to offer new families and offering suggestions about parenting classes and parent support groups;
- starting a father support group at your facility;
- providing brochures, videos, and information regarding SBS and SBS prevention at prenatal and early well-child visits; and
- supporting legislation that advocates for child abuse prevention programs and home visitation projects.

Physicians can help prevent SBS. Through education, public awareness, early intervention and support, physicians can lower the incidence of this tragic form of child abuse. We all have a role to play. MM

Jane Swenson is project director for "Awareness, Advice and Advocacy—The Child Abuse Project" at Midwest Children's Resource Center, Children's Health Care. Carolyn Levitt is a pediatrician, child abuse specialist, founder, and medical director of the resource center.

REFERENCES

1. A nation's shame: fatal child abuse and neglect in the United States. U.S. Advisory Board on Child Abuse and Neglect 1995: 8-16.
2. Caffey J. On the theory and practice of shaking infants: its potential residual effects of permanent brain damage and mental retardation. Am J Dis Child 1972;124:161-9.
3. Caffey J. The whiplash-shaken infant syndrome: manual shaking by the extremities with whiplash-induced intracranial and intraocular bleedings linked with residual permanent brain damage and mental retardation. Pediatrics 1974;54:396-403.
4. Duhaime AC, et al. The shaken baby syndrome: a clinical, pathological and biomechanical study. J Neurosurg 1987;66: 409-15.
5. Bruce D, Zimmerman RA. Shaken impact syndrome. Pediat Ann 1989;18(8):482-4.
6. Levin AV. Ocular manifestations of child abuse. Ophthalmol Clin North Am 1990;3:249-64.
7. Gilliland MGF, Luckenbach MW. Are retinal hemorrhages found after resuscitation attempts? a study of the eyes of 169 children. Am J Forensic Med Pathol 1993;14:187-92.
8. Duhaime AC, et al. Head injury in very young children: mechanisms, injury types, and ophthalmologic findings in 100 hospitalized patients younger than 2 years of age. Pediatrics 1992:172-85.
9. Buys UM, Levin AV, Enzenaven RW, et al. Retinal findings after head trauma in infants and young children. Ophthalmology 1992;99:1718-23.
10. Johnson DL, Braun D, Friendly D. Accidental head trauma and retinal hemorrhage. Neurosurgery 1993;33:231-5.
11. Ludwig S, Warman M. Shaken baby syndrome: a review of 20 cases. Ann Emerg Med 1984;13:104-7.
12. American Academy of Pediatrics. Shaken baby syndrome: inflicted cerebral trauma. Pediatrics 1993;92:872-5.
13. Mersery CJ, Towbin R, McLaurin RL, Myers PA, Ball W. Radiographic characteristics of skull fractures resulting from child abuse. Am J Roentgenol 1987;149:173-5.
14. American Academy of Pediatrics, Section on Radiology. Diagnostic imaging of child abuse. Pediatrics 1991;87:262-4.
15. Levitt CJ, Smith WL, Alexander RC. Abusive head trauma. In: Reece R, ed. Child abuse: medical diagnosis and management. Philadelphia, Penn.: Lea & Febiger, 1994:1-22.
16. Starling S, Holden J, Jenny C. Abusive head trauma: the relationship of perpetrators to their victims. Pediatrics 1995;95: 259-62.
17. Showers J. Shaken baby syndrome—the problem and a model for prevention. Child Today 1992;21:34-7.

Geographic Disparities in Medicare Reimbursement

A host of policies have been proposed to create an equitable reimbursement system.

Janet Silversmith

Geographic disparities in Medicare reimbursement rates are a source of frustration and concern to Minnesota physicians. For instance, to provide the same benefits to the same Medicare patients HMOs in Miami receive rates 84 percent higher than rates in Minneapolis. This is only one example of the significant variation that has been the subject of numerous articles and political debates. Reasons for the variation, the impact of the variation, and options for minimizing the disparity have received far less attention. This article explains the variation in Medicare reimbursements to HMOs, highlights how the variation impacts the program, and reviews policy changes that have been suggested to remedy the disparity.

Medicare's Use of Managed Care

As the U.S. Congress again debates how to pay for Medicare into the next century, nearly every proposal suggests increasing the use of managed care because it has the potential to reduce costs.

Medicare's use of managed care is not a recent phenomenon. In 1972, Congress recognized the potential for cost savings through HMOs or competitive medical plans (CMPs)* and amended the Social Security Act.[1] Public Law 92-603 provided prepayments to HMOs serving Medicare beneficiaries; however, the payment policy offered few incentives for HMO participation and, consequently, did not achieve the anticipated reduction in costs. One problematic provision of the policy required that any profits earned by the HMO (capped at 10 percent of the total payments received) were to be shared with the Health Care Financing Administration (HCFA); the financial risk facing the HMO, however, was unlimited.

Between 1980 and 1984, HCFA established a variety of risk contracts with HMOs on a demonstration project basis. In 1982, Congress changed the payment mechanism and created the Medicare risk contract program.[2] Changes in the law were incorporated in section 114 of the Tax Equity and Fiscal Responsibility Act (TEFRA); thus, the program is often referred to as the TEFRA risk contract program. The new payment policy, implemented in 1985, was developed not only to encourage HMO participation and, ultimately, cost savings, but also to recognize and compensate participating HMOs for the risk they have assumed.†

The AAPCC

The payment or capitation rate HCFA calculates and pays to Medicare risk contracting HMOs is called the adjusted average per capita cost (AAPCC). Because Congress saw the use of HMOs as a means of controlling program expenditures, the legislation establishing the risk contract program required HMO payments to be set at 95 percent of the costs Medicare would have incurred for HMO enrollees if they had remained in fee-for-service plans. As opposed to the 1972 version of HMO rate setting, the TEFRA provisions no longer required that HMO profits from Medicare be shared with HCFA. Instead, HMOs were allowed to keep all profits up to the level earned on their non-Medicare business; this amount is known as the adjusted community rate (ACR).[3] If estimated profits from the Medicare risk contract exceed estimated profits on the non-Medicare business, the excess dollars must be passed on to the enrollees in the form of reduced copayments or deductibles or as additional benefits. Otherwise, HMOs must refund the excess to HCFA.

HCFA employs four primary steps in calculating the risk contract payment rate. First, HCFA calculates the U.S. per capita cost (USPCC) using three years of Medicare historical spending data. Separate costs are calculated for Part A and Part B services for the aged, the disabled, and for persons with end-stage renal disease (ESRD). This "base rate" takes into account both payments and utilization of services. Second, HCFA adjusts the USPCC for geographic differences in Medicare fee-

*Hereafter referred to simply as HMOs.

†HMOs can serve Medicare patients through four programs: the risk contract program, a cost contract program, health care prepayment plans, and a social HMO. This discussion is limited to the risk contract program.

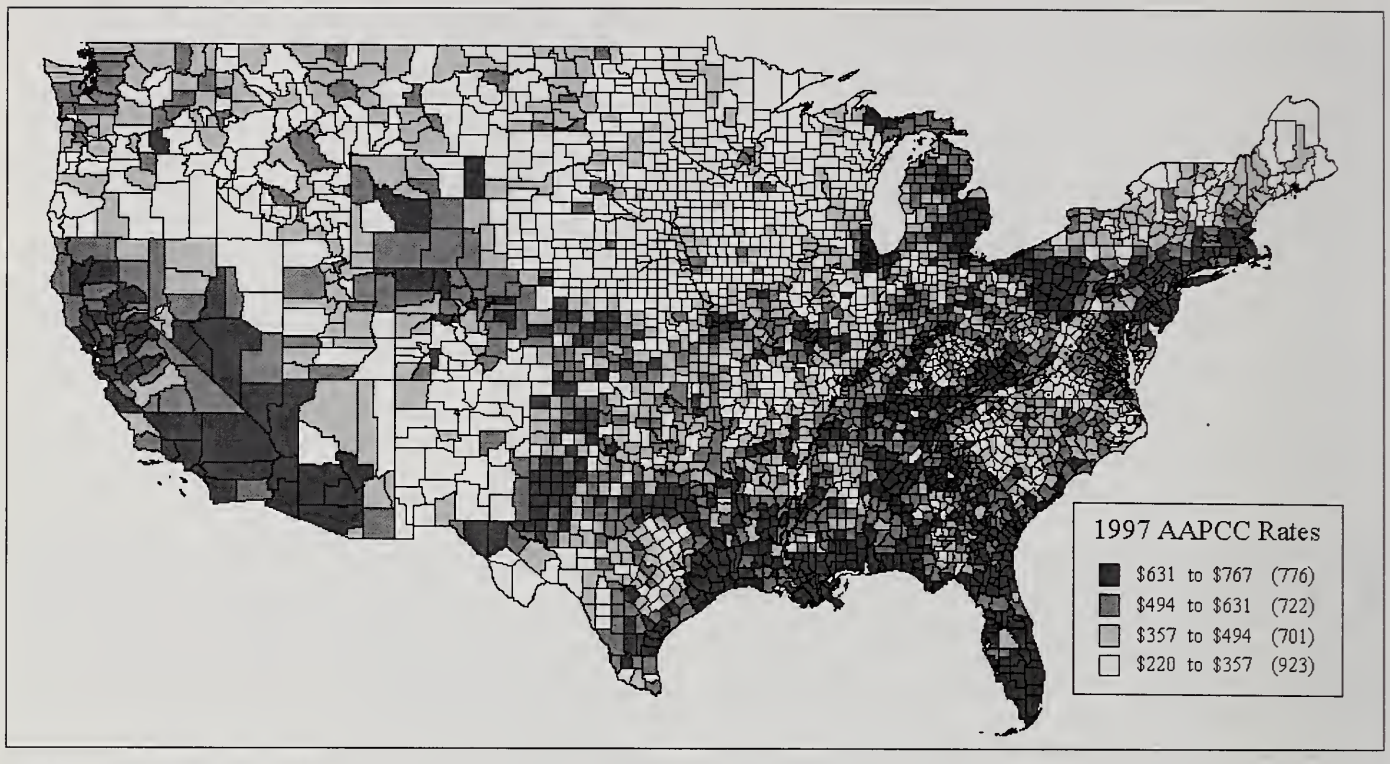


FIGURE 1—AAPCC rates, 1997

for-service expenditures (using a five-year moving average of fee-for-service claims data) to derive county-specific average per beneficiary costs. Third, HCFA multiplies the county rate by 0.95 to develop the county-adjusted average per capita cost—or AAPCC. Fourth, HCFA adjusts the AAPCC rate to account for demographic characteristics of HMO enrollees. Under HCFA's risk-adjustment system, beneficiaries are sorted into groups according to their demographic traits (age, sex, and Medicaid, institutional, and working status). The adjustment for the working aged was added in 1995.

HCFA calculates each demographic group's average cost in relation to the cost of all beneficiaries nationwide. For example, in 1995, the risk factor for younger seniors (65- to 70-year-old men) was .85, whereas for older seniors (85-year-old or older men) it was 1.3. The risk factors are applied to the AAPCC rates, thereby raising or lowering Medicare's per capita payment for each HMO enrollee, depending on the individual's demographic characteristics.[4] Under Medicare's risk-adjustment system, an HMO will receive a higher payment for enrolling an 80-year-old woman than for a 65-year-old woman who lives in the same county.[5] This means an HMO will receive more money for enrolling a healthy 80-year-old than for enrolling a 65-year-old with emphysema.

Most researchers conclude that the demographic risk adjusters used in the Medicare AAPCC formula are too simplistic—they do not explain enough of the variance in expenditures.[6] Explained variance is usually calculated using linear regression techniques to determine "goodness of fit" or R^2. The R^2 for Medicare's risk-adjustment technique has been calculated between 0.006 and .01; that is, the demographic risk adjusters are only able to predict 0.6 percent to 1 percent of the variation in individuals' annual Medicare expenditures.[7,8] Several researchers have attempted to determine how much variance in individuals'[‡] costs could or should be explained by a risk-adjustment mechanism; some have suggested estimates of 14 percent and 20 percent.[9,10] The precise level of variance that a risk-adjustment mechanism should estimate is not critical, as long as the mechanism captures as much information as insurers have available to them. There cannot be, and should not be, a perfect risk adjuster—one that could calculate and compensate for 100 percent of the variance.[6] Perfect predictive powers cannot be achieved because of random risk; they would not be desirable in a competitive market because such calculations would mute the differences between insurers based on administrative efficiencies and quality of care. Rather, a useful Medicare risk adjustment mechanism must have predictive power closely related to the health care costs of expensive beneficiaries. The demographic risk adjustment incorporated in Medicare's AAPCC formula has been shown to be extremely limited; many analysts have suggested that it be expanded to include some measure of health status, an important determinant of medical costs.[6,11,12]

The 1997 AAPCC rates are displayed in Figure 1. For

[‡]Most of the research has examined variation in individual health costs, which seems reasonable given the potential for individuals to be denied coverage. Some recent studies have begun to examine the variation in insurers' costs and compensate the plans that experience adverse selection. The potential benefit of this approach is the increased predictability of health care costs as the size of the group increases—the law of large numbers.

simplicity, the rates for Alaska, Hawaii, Guam, Washington, D.C., the Virgin Islands, and Puerto Rico are not included. The rates range from a low of approximately $221 in Arthur County, Nebraska, to a high of $767 in Richmond County, New York. The beneficiary-weighted mean is $467. In calculating the 1997 AAPCC rates, HCFA identified 3,248 counties, including the counties in the District of Columbia, Guam, the Virgin Islands, and Puerto Rico. The table shows the 10 counties with the highest and lowest AAPCC rates, excluding U.S. territories and possessions. Nine of the 10 highest AAPCC counties in 1997 were among the top 10 in 1996.

Figure 2 gives the 1997 Minnesota AAPCC rates. The average county rate (not weighted for beneficiaries) in Minnesota is $304.32, with a low of $227.30 in Chippewa County and a high of $422.41 in Ramsey County. All of Minnesota's 87 counties are below the national beneficiary-weighted mean of $467. Again, the AAPCC rates reflect the county-level differences in the prices of local medical services and in the utilization of those services by resident beneficiaries. If there are barriers to care for fee-for-service beneficiaries (e.g., lack of physicians in a rural area), AAPCC rates reflect low utilization for that county. Similarly, if beneficiaries in a county utilize a large quantity of services (e.g., increased demand, excess capacity), that utilization will be reflected in high AAPCC rates.[13]

Table

*Counties with highest and lowest AAPCC rates, 1997**

Ten highest AAPCC rates		Ten lowest AAPCC rates	
NY Richmond	$767.35	NE Arthur	$220.92
FL Dade	$748.23	NE Banner	$221.31
NY Bronx	$728.24	OH Holmes	$225.01
LA Plaquemines	$727.72	MN Chippewa	$227.30
LA St. Bernard	$719.84	TX Presidio	$229.70
NY New York	$713.12	NE Saline	$231.10
NY Kings	$705.37	NM Harding	$231.67
PA Philadelphia	$704.25	SD Fall River	$233.06
FL Okeechobee	$692.82	NE Gage	$234.71
TX Liberty	$677.79	NE Seward	$235.02

*U.S. territories and possessions are excluded from this analysis.

Medicare's Risk Contracting Program

Medicare's risk contracting program was implemented 12 years ago. As of April 1, 1997, only 12 percent (about 4.5 million) of all beneficiaries were enrolled in a TEFRA risk contract HMO.[14] Despite the relatively low enrollment levels, growth is occurring, and at increasingly higher rates. Beneficiary enrollment in the risk contract program increased by about 6 percent per year between 1987 and 1988; enrollment rates increased by nearly 16 percent between 1992 and 1993. Since 1993, however, annual enrollment growth rates have reached about 25 percent.[15]

The 4.5 million Medicare beneficiaries enrolled in the risk contract program are concentrated in a limited number of states. Figure 3 (page 48) shows the percentage of Medicare beneficiaries enrolled in risk contract HMOs throughout the United States. Two states, California and Florida, account for more than 50 percent of all risk contract enrollees. The addition of enrollees in Pennsylvania, New York, and Arizona accounts for more than two-thirds of all risk contract enrollees. Thirteen states have no risk contract enrollees: Alaska, Delaware, Idaho, Iowa, Maine, Mississippi, Montana, New Hampshire, North Dako-

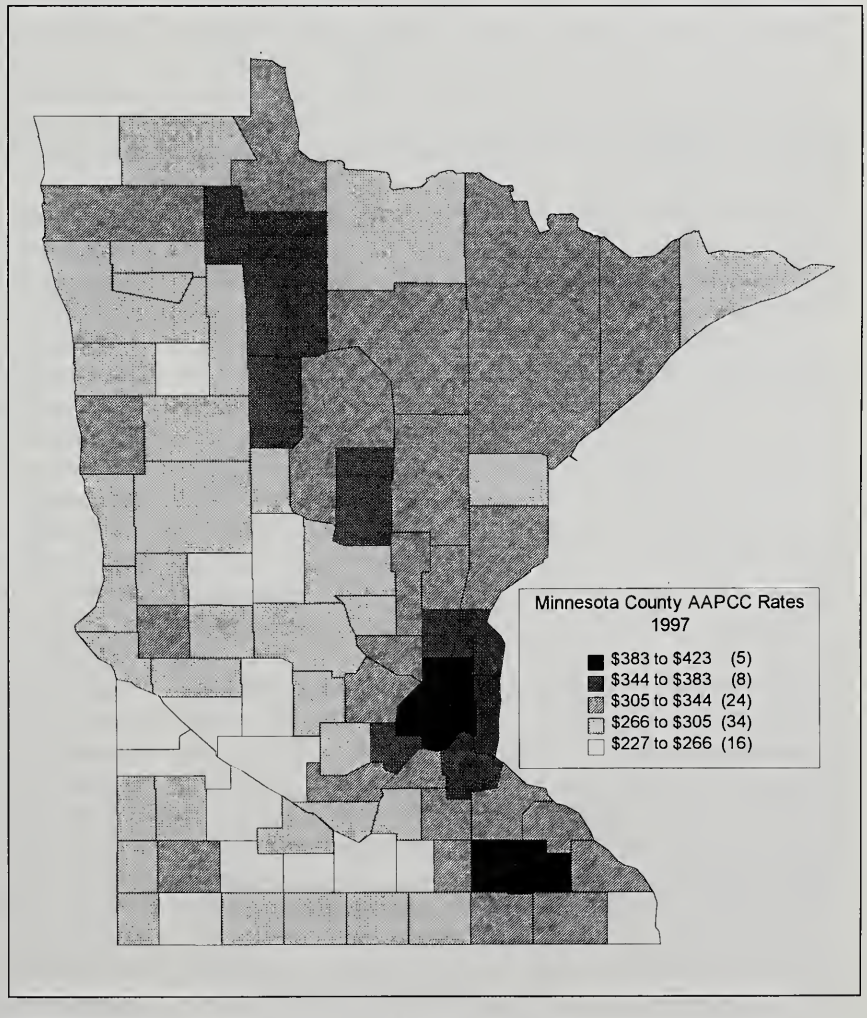


FIGURE 2—Minnesota AAPCC rates, 1997

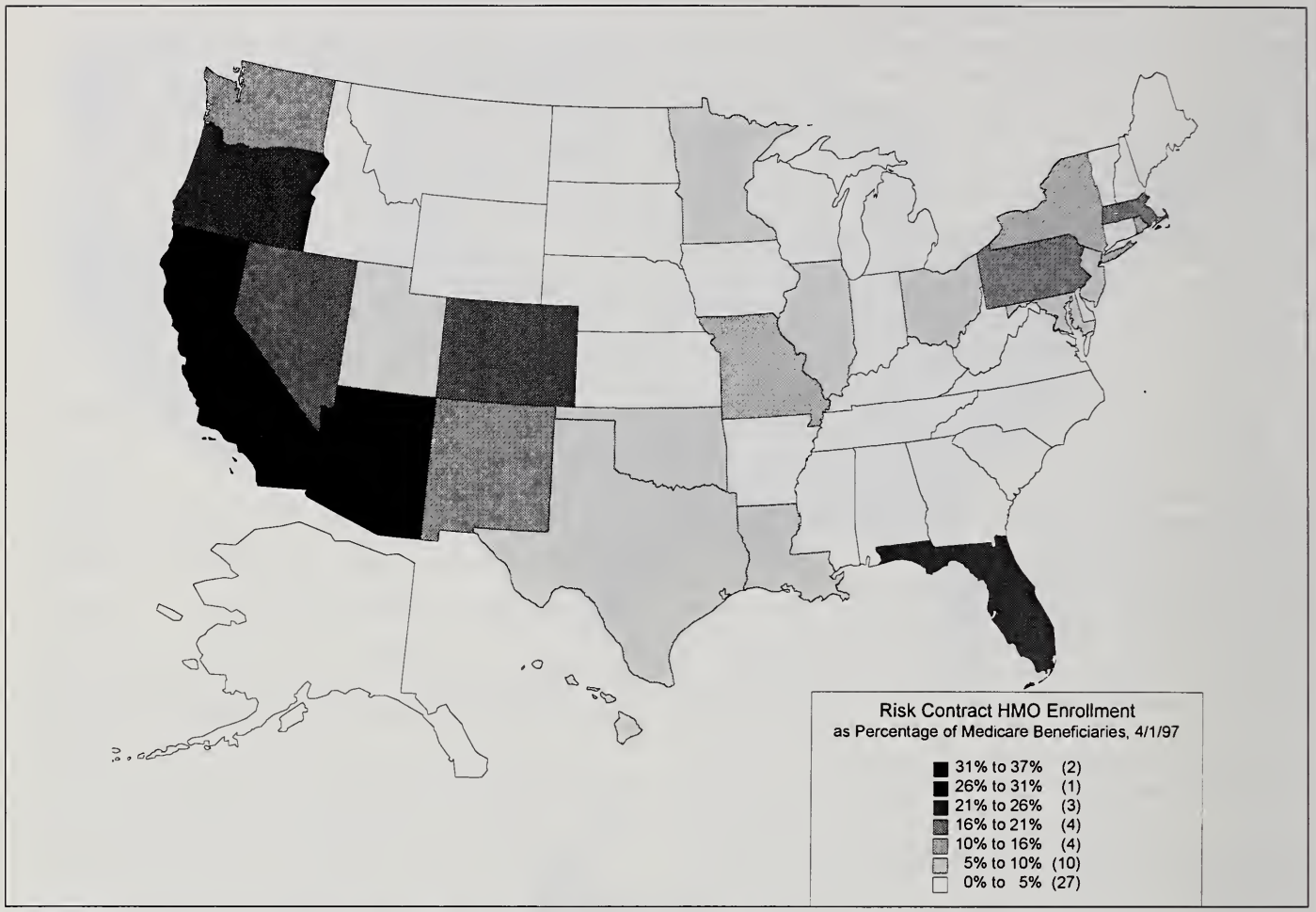


FIGURE 3—Medicare risk contract enrollment as percentage of Medicare beneficiaries, April 1, 1997

ta, South Dakota, Vermont, West Virginia, and Wyoming.[14] An additional 24 states (including the District of Columbia) have less than 1 percent of their beneficiaries enrolled in a risk contract HMO.

Currently, three HMOs in Minnesota have risk contracts with Medicare—Blue Plus, Group Health, and Medica.[14] They enroll about 60,000 Medicare beneficiaries, or about 10 percent of all state Medicare beneficiaries. By contrast, California risk contract HMOs enroll 37 percent of all Medicare beneficiaries in California. Enrollment in Minnesota's risk contract HMOs, like enrollment in every state, is limited to the counties in which HMOs can offer coverage. For the most part, coverage is limited to Medicare beneficiaries living in the Twin Cities metropolitan area.

As previously noted, an HMO's excess profits must either be passed on to the enrollees in the form of reduced copayments or deductibles, additional benefits, or be refunded to HCFA. This requirement, coupled with high AAPCC rates in many counties in the country, creates significant variation in the benefits available to Medicare beneficiaries and in HMO premiums. As of April 1, 1997, 67 percent of the risk contracts in effect charged no premium; many of these HMOs provided additional benefits, such as prescription drug coverage, eyeglasses, and hearing aids. Figure 4 (page 49) shows the distribution of risk contracts by the size of the premium charged to enrollees. The average premium is $11.84, with a range from $0 to $118. The three HMOs in Minnesota have premiums of $55.95, $57.50, and $64.00; only one of the plans includes prescription drug coverage.[16]

The geographic availability of a risk contract HMO, the size of the premium, and the scope of the benefits all influence both the number and type of beneficiaries who will enroll in the HMO. Based on 1993 data from the Medicare Current Beneficiary Survey (MCBS), Eppig and Poisal found that HMO enrollees were less likely to be disabled, had lower incomes, were more likely to rate their health as excellent or very good, and received more preventive services compared to beneficiaries in the fee-for-service Medicare program.[17] Numerous studies have concluded that Medicare HMOs do, in fact, experience favorable selection.[7,18-21] As a result, the risk contract program has increased Medicare costs, estimated at 5.7 percent to 28 percent above the costs in the fee-for-service Medicare program.[22] A recent study conducted by the U.S. General Accounting Office found that HCFA overpaid California HMOs $1 billion.[23]

Policy Levers

Numerous studies have documented the wide variation in Medicare risk contract rates, premiums, and benefits. A variety of proposals have been advanced to address the problems, and Congress and the Clinton Administration

have adopted some of the proposals as part of Medicare reform legislation. The strategies for improving Medicare's risk contract payment policy fall into three general categories: 1) maintain the AAPCCs, but improve how they are calculated; 2) use the AAPCC as the starting point, but eventually sever the link between local spending and utilization to calculate future rates that are less variable; and 3) adopt a competitive, market-based methodology for setting rates. The following discussion of these strategies identifies some of the complexities involved.

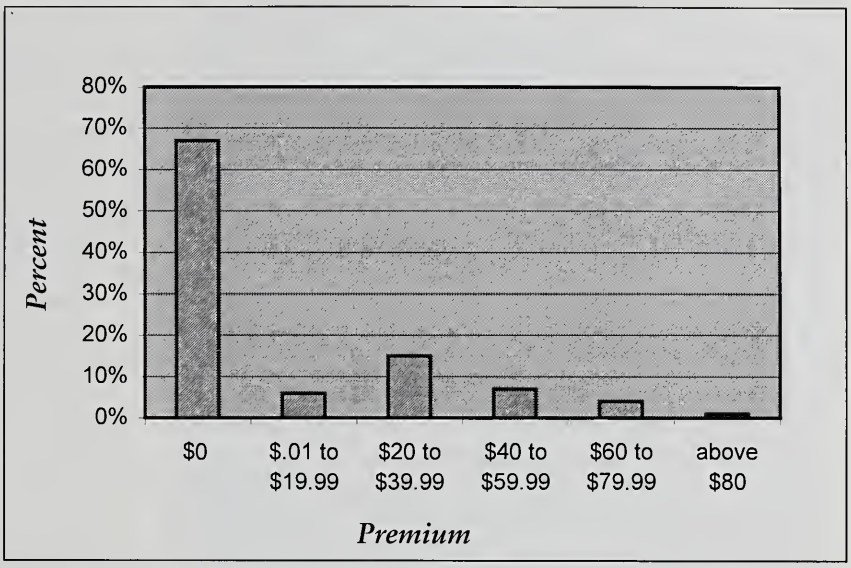


FIGURE 4—Distribution of risk contracts by premium charged to enrollees, April 1, 1997

Maintain the AAPCC

Specific policy changes would not dramatically alter the AAPCC methodology, but they would improve how component parts are calculated. One option would measure health status. An improvement in the risk-adjustment system could serve to address the favorable selection Medicare HMOs experience.

A second option would reduce the AAPCC base rates. President Clinton's fiscal year 1998 budget proposal incorporates this option and calls for a 5 percent across-the-board reduction (from 95 percent to 90 percent) in required savings from managed care of estimated fee-for-service expenditures. Although this proposal could account for total dollars Medicare loses because of favorable selection, it would not address favorable selection at the individual plan level.

A third option for improving the AAPCC that the Physician Payment Review Commission has recommended would vary payment rates by the length of enrollment in the HMO (i.e., new enrollees have lower costs and should also have lower rates). Another policy option that has generated significant interest would remove the graduate medical education and disproportionate share payments from the AAPCC; the funds would be distributed directly through explicit new mechanisms to the facilities incurring medical education costs and serving a disproportionate share of Medicare patients. This proposal, while controversial among many HMOs, is part of President Clinton's budget proposal and appears to have captured the support of many members of Congress.

The final policy option would change the method of estimating the "base rate" to include the expected costs of the HMO enrollees. This provision, developed as a result of the General Accounting Office study of HMO rates in California, would estimate HMO enrollees' expected fee-for-service costs. HCFA estimates costs for only those beneficiaries who remain in the fee-for-service sector, and it ignores the costs HMO enrollees would have incurred if they had remained in fee-for-service.[23]

Use the AAPCC as the starting point

The policy options considered under this approach have received the greatest attention because they offer to reduce the variation in payment rates. Despite pressure to increase payment rates, studies have documented that the AAPCC rate is not as predictive of Medicare HMO enrollment as HMO penetration in the general health care market. Minnesota provides a good example. Minnesota's average AAPCC rate is the second lowest in the country, at $304.32. Only Nebraska's is lower, at $292.05. Despite Minnesota's low rates, however, 10 percent of Minnesota's Medicare beneficiaries are enrolled in a risk contract HMO. The fact that approximately 25 percent of Minnesota's population is enrolled in HMOs may help explain Minnesota's Medicare HMO enrollment.[24]

One of the policy options being considered in this category calls for setting local rates that are predominantly based on national rates. This provision would seek to set rates that reflect variation in local input costs, rather than on practice styles or excess capacity.

A second option would define payment floors or ceilings to more immediately redistribute the dollars from the very high to the very low counties. President Clinton's proposed budget would set a payment floor of $350 in 1998. Although it is unclear whether the $350 floor would result in increased risk contract enrollment, 75 of Minnesota's 87 counties currently have rates below $350.

The final policy option within this category would change the geographic unit for calculating the AAPCC from single counties to larger market areas, such as metropolitan statistical areas. The purpose of this option is to reduce the volatility in payment rates caused by limited data for small geographic areas. For example, Loving County, Texas, which has fewer than 20 Medicare beneficiaries, had the highest AAPCC rate in 1996, $881. In 1997, however, the rate dropped about 40 percent to $527. ⇨

Geographic Coalition

The Geographic Coalition is a nonpartisan group of state medical associations committed to achieving a more equitable Medicare reimbursement system by reducing the geographic variation in fee-for-service and managed care payment rates. The coalition was originally created in 1989 to respond to geographic disparity in reimbursement rates during the implementation of RBRVS. The coalition was reestablished in 1995 and formalized in 1996 with 24 member states, representing almost 162,000 physicians. The purpose of the coalition is to develop grassroots support for policies that will reduce the geographic variation in Medicare reimbursement rates. The coalition has adopted the following policy positions:

- It is not interested in advocating one type of delivery system over another.
- It supports congressional reform proposals that maintain the solvency of the Medicare program, while maintaining legitimate choices for Medicare enrollees.
- It supports a requirement that HCFA, as part of the five-year review of relative value units, evaluate the fee-for-service payment areas to ensure that demographic or other economic changes have not inappropriately altered market areas.
- It supports incorporation of a health status measure in Medicare's risk adjustment methodology.
- It supports efforts to improve the method for calculating the base rate (options could include lower rates for new enrollees or new methods of estimating expected costs).
- It supports, as a first step, the development of a payment floor that will begin to redistribute dollars more equitably; ideally, the coalition encourages adoption of policies that would eliminate the direct link between local fee-for-service spending and the AAPCC rates through the blending of national and local rates to develop rates that reflect variation in input costs, not practice patterns.
- It supports efforts to reduce the volatility of rates by consolidating counties into larger payment areas (such as metropolitan statistical areas) that are more reflective of natural market areas. *–JS*

Adopt a competitive methodology for setting rates

The central policy option offered under this approach is the adoption of a competitive bidding model for the Medicare program. This option represents the most radical of the options available and is not likely to be adopted in the short term. HCFA is conducting a competitive bidding demonstration project in Denver. The demonstration was originally scheduled to occur in Baltimore, but vigorous opposition from health plans forced the relocation of the project.

Conclusion

Medicare's risk contract program has inherent problems, yet researchers have developed realistic solutions, and changes will likely occur if Congress enacts Medicare reform. The bigger question may be whether Medicare reform will occur. Although Congress and the Clinton administration reached a balanced budget agreement on May 2, the fact that Congress did not adopt a budget resolution by April 15, as required, should not be forgotten. The budget agreement calls for a reduction in Medicare spending of $115 billion over five years. Few details are known, however, as *Minnesota Medicine* goes to press. Whether Congress will change the AAPCC rates remains unclear. If Congress does not change the risk contract rate-setting process, the biggest losers will be Medicare beneficiaries, both current and future. MM

Janet Silversmith is a health policy analyst at the Minnesota Medical Association. She has a master's degree in policy analysis from the University of Minnesota's Humphrey Institute of Public Affairs.

REFERENCES

1. U.S. General Accounting Office. Medicare changes to HMO rate setting method are needed to reduce program costs. Washington, D.C.: General Accounting Office, 1994:12. Report 94-119.
2. Tax Equity and Fiscal Responsibility Act, Pub. L. No. 97-248.
3. U.S. General Accounting Office. Medicare changes to HMO rate setting method are needed to reduce program costs. Washington, D.C.: General Accounting Office, 1994:13. Report 94-119.
4. Ratner J. Testimony before the U.S. House of Representatives Subcommittee on Health and Environment, Committee on Commerce, 27 February 1997.
5. U.S. General Accounting Office. Medicare changes to HMO rate setting method are needed to reduce program costs. Washington, D.C.: General Accounting Office, 1994:17. Report 94-119.
6. Newhouse J, Manning W, Keeler E, Sloss E. Adjusting capitation rates using objective health measures and prior utilization. Health Care Financ Rev 1989;10(3):41-53.
7. Lubitz J, Beebe J, Riley G. Improving the Medicare HMO payment formula to deal with biased selection. In: Scheffler R, Rossiter L, eds. Advances in health economics and health services research. Greenwich, Conn.: JAI Press, 1985:101-22.
8. Anderson G, Cantor J, Steinberg E, Holloway J. Adjusting for prior utilization and physician discretion. Health Care Financ Rev 1986;8(2):27-34.
9. McCall N, Wai H. An analysis of the use of medicare services by the continuously enrolled aged. Medical Care 1983;21(6):567-85.
10. Newhouse J. Is competition the answer? J Health Econ 1982; 1(1):109-15.
11. McClure W. On the research status of risk-adjusted capitation rates. Inquiry 1984;21(3):205-13.
12. Thomas JW, William J, Lichtenstein R. Functional health measures for adjusting health maintenance organization capitation rates. Health Care Financ Rev 1986;7(3):85-95.
13. U.S. General Accounting Office. Medicare changes to HMO rate setting method are needed to reduce program costs. Washington,

D.C.: General Accounting Office, 1994:35-6. Report 94-119.
14. Medicare managed care contract report. HCFA 1997 April 1.
15. U.S. General Accounting Office. Medicare HMOs: rapid enrollment growth concentrated in selected states. Washington, D.C.: General Accounting Office, 1996:18.
16. Health Care Financing Administration Monthly Report. Medicare managed care plans. HCFA 1997 April.
17. Eppig FJ, Poisal JA. Medicare FFS populations versus HMO populations: 1993. Health Care Financ Rev 1996;17(3):263-7.
18. Brown R, Hill J. Biased selection in the TEFRA HMO/CMP program. Report to HCFA. Washington, D.C.: Mathematica Policy Research, Inc., 1990.
19. Eggers P. Risk differential between Medicare beneficiaries enrolled and not enrolled in an HMO. Health Care Financ Rev 1980;1(3):91-9.
20. Eggers P, Prihoda R. Pre-enrollment reimbursement patterns of Medicare beneficiaries enrolled in 'at-risk' HMOs. Health Care Financ Rev 1982;4(1):55-73.
21. Brown R, Bergeron J, Clement D, et al. Does managed care work for Medicare? an evaluation of the Medicare risk program for HMOs. Washington, D.C.: Mathematica Policy Research, Inc., 1993.
22. U.S. General Accounting Office. Medicare changes to HMO rate setting method are needed to reduce program costs. Washington, D.C.: General Accounting Office, 1994:22. Report 94-119.
23. Scanlon W. Testimony before the U.S. House of Representatives Subcommittee on Health, Committee on Ways and Means, Feb 25, 1997.
24. Baumgarten A. Minnesota managed care review. Minneapolis, Minnesota: Allan Baumgarten, 1996.

Wilderness Charm and Cosmopolitan Amenities

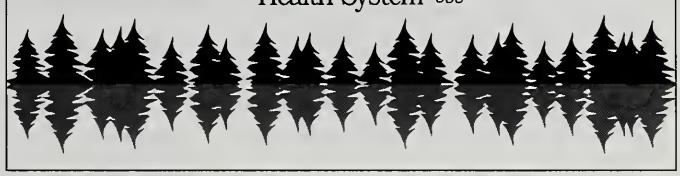
St. Mary's/Duluth Clinic Health System, a 300-physician multi-specialty group, with 3 hospitals and 22 neighborhood & regional centers serving a referral population of 460,000, seeks physicians in the following areas:

EP Cardiology	Orthopedic Surgery
Dermatology	Ophthalmology-Retina
Emergency Medicine	Pathology
Family Practice	Pediatrics
Internal Medicine	Psychiatry – Adult
Nephrology	Psychiatry – Child
Neurosurgery	Rheumatology

We offer a complete compensation package, including excellent fringe benefits and generous vacation/CME time. Only here can you listen to a duet of loons and a symphony orchestra in the same evening.

Contact Mike Griffin Marci Jackson or Jocelyn Heid, SMDC, 400 E. 3rd St., #500, Duluth, MN 55805 or call 1-800-342-1388 or fax 218-722-9952 or e-mail to: sr@smdc.org

SMDC
St. Mary's/Duluth Clinic Health System eoe



Suburban Family Practice Opportunity

Our HealthPartners' Bloomington Clinic offers family practitioners the opportunity to practice primarily adult medicine in a team oriented atmosphere. We currently have a full time opening combining trauma, orthopedics and sports medicine in an ambulatory setting.

To learn more, contact Lori Fake at (612) 883-5337, (800) 472-4695 or via e-mail: lori.m.fake@healthpartners.com. For consideration, forward your CV to: HealthPartners, Physician Services, P.O. Box 1309, Minneapolis, MN 55440. EO/AA Employer

HealthPartners
HealthPartners' mission is to improve the health of our members and our community

Park Nicollet Clinic HealthSystem Minnesota

Urgent Care Department

- BC/BE family practitioners, general internists, or emergency medicine practitioners
- Burnsville, Brookdale, Carlson Center, and St. Louis Park offices
- Varied and challenging patient population
- Flexible scheduling options, all considered full-time with same base pay
  - #1 40 hrs/wk, no evenings/no weekends
  - #2 36 hrs/wk, 6 hrs of evenings/weekends
  - #3 32 hrs/wk, 12 hrs of evenings/weekends
  - #4 28 hrs/wk, 18 hrs of evenings/weekends
- A 411-physician Multispecialty Clinic
- Contact Patric Moylan at 612/993-5986
  or
- Send CV and letters of inquiry to:
  Professional Practice Resources
  Park Nicollet Clinic
  3800 Park Nicollet Boulevard
  St. Louis Park, MN 55416
  or
  Fax 612/993-2819

Are Medical Savings Accounts an Effective Insurance Alternative?

A recent health insurance act has stirred up discussion over the controversial MSA.

Kimberly Halva, J.D.

When medical savings accounts (MSAs) were first introduced in the mid-1980s, the debate focused on their effectiveness to reform health care. Now, the enactment of the Health Insurance Portability and Accountability Act of 1996 has again ignited discussion as to whether MSAs are an effective method of health care reform.

MSAs are tax-sheltered savings accounts that individuals or employers can use to pay for medical expenses. In conjunction with an MSA, individuals purchase catastrophic insurance, which covers any medical expenses above the deductible.

Proponents argue that MSAs motivate consumers to make rational and prudent health care spending decisions. Critics claim that MSAs place an unreasonable burden on consumers and shift the cost of health care to individuals who can least afford it. Despite persuasive arguments on both sides, MSAs are a largely untested insurance product with a number of theoretical advantages as well as potentially serious drawbacks.[1] This article describes MSAs and presents some of the arguments made for and against the MSA concept.

How MSAs Work

Insurance companies offer MSAs, in conjunction with a high-deductible or catastrophic health insurance policy, as an alternative to traditional health insurance. Individuals or employers purchase a less-expensive catastrophic insurance policy and deposit a set dollar amount into a tax-sheltered savings account (the MSA). Policyholders can then withdraw funds from the MSA to pay for medical expenses up to the deductible of their catastrophic insurance policy. The policy covers medical expenses above the deductible.

MSAs resemble flexible spending accounts. Contributions to MSAs can be deducted from federal income taxes, and most withdrawals aren't taxed if used to pay for medical care. Unlike flexible spending accounts, however, MSAs allow individuals to carry any balance remaining in their account forward to the following year. These accumulated contributions are also tax-deferred and can be used for future medical expenses, such as long-term care.

Advantages of MSAs

Proponents argue that MSAs offer consumers three primary advantages: MSAs make individuals better consumers of medical care, MSAs strengthen the physician-patient relationship, and MSAs offer more security because consumers own their own coverage.

First, advocates claim, MSAs help consumers understand medical costs and make better decisions about the care they purchase. Because consumers consider MSAs a cash savings account, they perceive the money as their own. They therefore tend to avoid unnecessary care and shop for the provider with the best price, as they would with a cash savings account.

A second advantage MSAs offer is that consumers and providers are not tied to a provider system or network. Instead, consumers can choose among competing providers to obtain services that best meet their needs. Likewise, providers don't feel pressure from third-party payers to withhold beneficial care or obtain preauthorization for necessary treatments.[2] So providers make medical decisions without interference from third-party payers. (Currently, nearly 80 percent of personal health care spending in the United States occurs through third-party payments.[3] Some critics say that relying on the third-party system makes consumers reckless purchasers of health care.) In short, proponents argue, MSAs strengthen the traditional physician-patient relationship under the fee-for-service system.

Third, MSAs give consumers more flexibility and security because individuals "own" the accounts. For many consumers, health care coverage is tied to employment, and insurance benefits do not necessarily transfer from one employer to the next. Regardless of employment status, MSAs allow consumers to retain the balance in their account and continue to cover out-of-pocket medical expenses.

Disadvantages of MSAs

The MSA concept also has its critics, who have four main concerns: MSAs place an unreasonable burden on consumers to make decisions about their health care, MSAs may actually cost consumers more, MSAs shift

the cost of health care to consumers who can least afford it, and MSAs encourage consumers to forgo early treatment and preventive care.

Critics claim that MSAs wrongly assume that consumers have reliable information about price, quality of care, and alternative treatments when purchasing and evaluating health care. Most large HMOs build quality measures into their overall benefits packages but don't educate consumers about quality and cost of the services they provide.[4] Nor do state agencies or private organizations give consumers this information.

A second disadvantage of MSAs is that consumers who don't understand how MSAs and catastrophic insurance work together may end up paying more for health care than they anticipate. Often, catastrophic insurance policies narrowly define covered services, making it easy for consumers to exhaust the money in their MSAs on expenses that don't count toward their insurance deductible.[5] For example, many catastrophic policies don't count dental care expenses toward the deductible. If consumers spend all the money in their MSA on dental expenses and then incur significant medical costs, they will have to pay for these costs out-of-pocket until they reach the deductible limit. For many consumers, such unexpected medical expenses could be financially devastating.

Critics also warn that MSAs upset the traditional balance between high- and low-risk beneficiaries, thereby shifting the cost of health care to those consumers who can least afford it. Clearly, MSAs are financially advantageous for consumers who are relatively healthy and who do not spend a lot on health care. If MSAs were to become available to all consumers, younger and healthier individuals would likely switch, while high-risk consumers would remain in more traditional plans. The result? Money previously distributed equally among all consumers would no longer be in the system, causing traditional insurance premiums to increase as much as 61 percent.[6] Healthy individuals could also use MSAs to accumulate tax-advantaged savings when their health costs are low, then shift to comprehensive health plans when their costs are higher. Again, the risk-sharing system would be disrupted, causing traditional insurance premiums to rise significantly.

Finally, critics argue that MSAs encourage consumers to forgo early treatment and preventive care. What some perceive as an incentive, namely, to view MSAs as personal savings accounts, may actually encourage consumers to pass up preventive care in order to keep a large balance in their accounts. Consumers may realize immediate savings for forgoing treatment, but they will likely have higher future health care costs, and may, in fact, jeopardize their health.

Conclusion

MSAs will likely encourage consumer responsibility and self-restraint in health care spending decisions. However, MSAs are likely to cause problems for consumers as well. Just how beneficial or harmful MSAs are to the American health care system remains to be seen. MM

Kimberly Halva is the associate legal counsel at the Minnesota Medical Association.

Summary of MSA Legislation

The first piece of legislation to address medical savings accounts (MSAs) was the Health Insurance Portability and Accountability Act of 1996. The act created a four-year medical savings account (MSA) pilot project. Participation in the project is limited to anyone who is currently uninsured, and up to 750,000 persons nationwide who are self-employed or employees of businesses with 50 or fewer employees. The maximum deductible allowed for the catastrophic plan is $2,250 for individuals and $4,500 for families. Individuals can make a maximum annual contribution of 65 percent of their deductible; families can contribute up to 75 percent. The act allows participants to withdraw, for any reason, the money remaining in their MSA when they reach age 65.

Minnesota has no legal equivalent of the Health Insurance Portability and Accountability Act that specifically allows for the creation of MSAs in the state. However, Minnesota law does not preclude individuals or employers from purchasing high-deductible insurance policies and setting up savings accounts for medical expenses. The difference is that the state taxes money deposited into these types of savings accounts.

Individuals interested in learning more about setting up a Medical Savings Account should consult their financial advisers.

REFERENCES

1. Rabinowits HK. Medical savings accounts: health system savior or insurance scam? JABFP 1997;10:50-4.
2. American Medical Association. Medical savings accounts: why the American Medical Association supports medical savings accounts. November 1994.
3. Lyke B. Medical savings accounts. Congressional Research Service Report prepared for Congress, no. 940-597 EPW. Washington, D.C.: Congressional Research Service, 1994.
4. Minnesota Department of Health. Medical savings accounts. Health Economics Program Issue Paper. January 1996.
5. Jeffrey N. Medical savings accounts offer benefits, risks. Wall Street Journal 1996 May 1.
6. American Academy of Actuaries. Medical savings accounts: cost implications and design issues. Public Policy Monograph 1;May 1995:9.

People and Places Making Medical News

People

MAFP Announces Awards, Officers

The Minnesota Academy of Family Physicians (MAFP) announced its 1997 award winners: **James Mohs, M.D.**, Melrose, Minnesota Family Physician of the Year; **Kirk Simpson, M.D.**, Bloomington, Merit Award; **Peter Harper, M.D.**, St. Paul, Teacher of the Year; **Sandra Zurcher Beulke, M.D.**, Duluth, and **Patrick Rock, M.D.**, Minneapolis, tied for Resident of the Year; **Sue Nielsen**, Medical Student Award for Contributions to Family Medicine.

The academy also elected its 1997-98 officers: **Timothy Komoto, M.D.**, Eagan, president; **Jamie Peters, M.D.**, Minneapolis, vice president; **David Thorson, M.D.**, White Bear Lake, president elect; **Patricia Lindholm, M.D.**, Fergus Falls, board chair/speaker of the house; **Keith Stelter, M.D.**, Moose Lake, vice speaker; **Pamela Gades Dumke, M.D.**, Maple Grove, treasurer; **Robert Bosl, M.D.**, Starbuck, and **Jerry Rogers, M.D.**, Moorhead, AAFP delegates; **Raymond Christensen, M.D.**, Moose Lake, and **Nancy Baker, M.D.**, St. Paul, AAFP alternate delegates.

Allina Executive Receives Leadership Award

David Strand, system vice president of Allina's Market and Network Management and president of Medica Health Plans, is one of four recipients of the Healthcare Forum's 1997 International Emerging Leaders in Healthcare Award. Strand was chosen for his management abilities, applied creativity and innovation, professional growth, and transformational leadership qualities.

The International Emerging Leaders program began 13 years ago to recognize health care leaders age 40 and younger who are working to create healthier communities on a local, national, and international level. The Healthcare Forum is a San Francisco-based organization that engages leaders in building new visions and models of care for individual, organizational, and community health.

New HealthEast Medical Directors

Frank Indihar, M.D., medical director of HealthEast's Respiratory Care Unit since 1978, has become medical director of HealthEast Bethesda Hospital. He replaces **Robert Beck, M.D.**, who served as acting director for the last several years. **Patrick Wright, M.D.**, board certified in internal medicine, pulmonary diseases, and critical care medicine, is the new medical director of the Respiratory Care Unit.

HealthPartners Names Internal Medicine Head

HealthPartners named **Stanley Russin Jr., M.D.**, internal medicine department head as part of the HealthPartners Medical Group and Clinics. Before joining HealthPartners, Russin served as deputy chairman for clinical affairs, chief for the section of general internal medicine, and director of managed care for the department of medicine at Temple University School of Medicine in Pennsylvania.

Russin also served as physician adviser for utilization management and performance improvement at Temple University Hospital, as well as medical director for the hospital's Health Partners Network.

'U' Academic Health Center Hires Communications Director

Christine Roberts, deputy to the chancellor for public affairs at Minnesota State Colleges and Universities (MnSCU), has been named communications director at the University of Minnesota Academic Health Center (AHC).

At MnSCU, Roberts was responsible for systemwide marketing, communications, public relations, and development. Before 1995, she held several senior-level positions with the Minnesota State Universities, most recently as vice chancellor for system advancement. She also served as higher education adviser to **Gov. Arne Carlson.**

Sister Kenny Selects New Board Members

Abbott Northwestern's Sister Kenny Institute has appointed six new active members and one life member to its board of trustees.

New board members are **William A. Diaz, Ph.D.**, St. Paul, senior fellow with the University of Minnesota's Humphrey Institute; **John Hardeman**, Golden Valley, director of the Jack Cornelius Boys and Girls Club/Phillips Community Center; **James Hornig**, Wayzata, president and CEO of Woodland Capital Corporation and president elect of the Minnesota Landscape Arboretum; **James R. Larson, M.D.**, Edina, an orthopedic surgeon and president of Abbott Northwestern's medical staff and medical director of the hospital's Minimally Invasive Care Center; **Michael Patrick**, Minneapolis, president of Patrick Communications, Inc.; and **Diane Pennock**, Minnetonka, studio director for The Marsh, a comprehensive wellness and fitness center.

Richard R. Owen, M.D., former medical director for Sister Kenny Institute, has been elected a life member of the board.

HealthSystem Minnesota Recognizes Six Nurses

HealthSystem Minnesota recognized six nurses for the outstanding care they provide patients and families and for their community service. **Kathleen Cummings, R.N., M.S.N.**, Edina, received the Sarah Harrison Knight Leadership Award for her professional leadership on

the job and in the community.

Five other nurses were recognized as Nurses of Excellence: **Janice Pearson, R.N.**, Golden Valley, director of patient education for the International Diabetes Center at Park Nicollet Clinic; **Sandy Sannes, R.N., M.H.A.**, Golden Valley, director of patient services for Standards and Regulatory Compliance, Methodist Hospital; **Brenda Solarz-Johnson, R.N.**, Golden Valley, charge nurse and clinical resource nurse in the oncology unit at Methodist Hospital; **Mary Sladek, R.N.M.S.**, Orono, cancer control nurse for prevention studies at Methodist Hospital and breast cancer nurse coordinator in the Department of Defense breast cancer study; and **Paulette Hurd, L.P.N.**, Minneapolis, nurse in family practice at Park Nicollet Clinic–St. Louis Park.

Foundation HealthSystem Minnesota Names Board Members

The Foundation HealthSystem Minnesota has elected four new members to serve on its board of directors. **Deborah L. Fowler, Ph.D.**, is an organizational psychologist with more than 15 years' business experience. **Michael L. Kremer, Ph.D.**, is superintendent of Hopkins School District. **William S. Shimp, M.D.**, is senior vice president of hospital and consultative services for HealthSystem Minnesota. **Alan V. Johnson** is president of the west suburban market for Norwest Bank Minnesota.

Allina Exec Resigns

John Grotting, system vice president of Care Delivery Operations for Allina Health System, resigned May 1, 1997, to take over as president of Bridge Medical, Inc., a San Diego-based biomedical company. Bridge Medical develops technologies and information systems that help health care providers reduce medication errors, improve patient outcomes, and lower the cost of providing drug therapy.

Places

Struthers Parkinson's Center Named Center of Excellence

The Struthers Parkinson's Center of Methodist Hospital Health-System Minnesota has been named a Center of Excellence by the National Parkinson Foundation (NPF). The only NPF Center of Excellence in Minnesota, Struthers is one of 49 such centers worldwide.

The center provides comprehensive assessment and treatment

HealthEast Capitol Medical Laboratory

The Solution to Your Reference Laboratory Needs

Locally owned and operated

Accurate cost-effective testing
24 hours a day, 7 days a week

Technical consultant services

Continuing education seminars

Providing services to:

• physician office laboratories •

• long-term care facilities •

• group home •

• home health care agencies •

For more information, contact
CML Marketing at (612) 232-3246

HealthEast Capitol Medical Laboratory
69 West Exchange Street
St. Paul, MN 55102-1004
Customer Service: (612) 232-3500

Discover Greater Minnesota through locum tenens!

Minnesota Rural Physician Support Program:

- High quality, not-for-profit locum tenens program
- Variety of rural opportunities
- Competitive wages

Contact: Minnesota Center for Rural Health
600 E. Superior Street, Suite 404
Duluth, MN 55802
Phone: 1-800-997-6685
Fax: (218) 727-9392
E-mail: mcrh@d.umn.edu
Home page: http://www.d.umn.edu/mcrh

Information on practice opportunities, loan repayment, compensation packages, and contract review also available.

Administered by the University of Minnesota and the Minnesota Center for Rural Health

Weigh The Facts!

Benefits to clinics, hospitals and practitioners include:
-Large pool of seasoned physicians.
-Integral part of medical referral network.
-Current in medical care policies, procedures and protocol.

To physicians of all specialties:
-Confidentiality prioritized.
-Financial incentives.
-Medical malpractice.
-Personalized service tailored to your needs.



Whitesell
Medical Locums, Ltd.

Eight First Avenue South
Buffalo, MN 55313
1(800) 876-7171
1(800) 295-6373
Local 682-5218 or 682-5906
FAX (612) 682-4791

for Parkinson's at every stage of the disease. The center also conducts drug trials, genetic research, and surgical studies. Its CREATE program uses music, art therapy, movement, exercise, horticulture therapy, and meditation with Parkinson's patients.

Nonprofit Health Center Focuses on Family Health and Faith

The Soteria Family Health Center, a nonprofit center that focuses on "genuine family medicine," has opened in Robbinsdale. Services include adult medicine, allergy shots, general physical exams, geriatric medicine, laboratory tests and diagnostic x-rays, mental health care, and counseling.

Medical providers at the center believe that a person's physical and emotional health are correlated with their spiritual health. "We are open to working with patients who want to explore how their faith affects their health," said **Ruth A. Bolton, M.D.**, medical director. Bolton is former director of the Family Practice Residency Program for the University of Minnesota at North Memorial Medical Center.

Abbott Moves Anesthesia School to St. Mary's

Abbott Northwestern Hospital has transferred its anesthesia school to St. Mary's University of Minnesota. The move follows a trend away from hospital-based anesthesia schools, according to the American Association of Nurse Anesthetists. To maintain accreditation, anesthesia schools are required to have master's programs by 1998. St. Mary's has a Masters of Arts degree in anesthesia.

The Abbott Northwestern Anesthesia School opened in 1952 when the demand for nurse anesthetists exceeded the supply, and the educational standards were different from those today.

'Starter Kits' to Help Prepare St. Paul Parents

Children's Health Care and the St. Paul-Ramsey County Children's Initiative have developed a "parent starter kit" for new parents in St. Paul with 3M Foundation funding. The kit includes information on child health, parenting, and reading. Volunteers from the St. Paul-Ramsey County Children's Initiative and the St. Paul neighborhood Family Centers hope to distribute 10,000 kits this year, the same number of babies estimated will be born in the city during that time.

Most starter kits will be delivered directly to the homes of new parents in St. Paul within two to four weeks of the birth of a child. Public health nurses will distribute the other kits during regular home visits.

Socioeconomics

Mayo, Illinois Health System May Merge

The Mayo Clinic is discussing plans to merge with Rockford Health System, one of the largest health care systems in north-central Illinois. The proposed merger would further Mayo's strategy of establishing a regional network of clinics and hospitals that refer patients to Mayo's specialists at its Rochester headquarters.

Rockford Health System serves a 14-county area and includes the 491-bed Rockford Memorial Hospital with 2,600 employees, the Rockford Clinic's 12 locations and 175 physicians, and Rockford Health Plan, an HMO with 50,000 members.

UCare Minnesota, Mayo Health Plan Collaborate

UCare Minnesota and Mayo Health Plan will collaborate to offer a new health plan option for individuals in southeastern Minnesota who are eligible for MinnesotaCare and the Prepaid Medical Assistance Program. The new plan, which affects more than 16,000 people in 15 counties, combines Mayo Health Plan's provider network with UCare's preventive care programs and expertise in working with individu-

als enrolled in government health programs.

The new plan will provide members with standard MinnesotaCare services as well as UCare's preventive programs. Members will be able to choose a physician from Mayo Health Plan's network of providers and will have access to Health Connection, a 24-hour health resource line staffed by Mayo Clinic registered nurses. Members can also participate in UCare's prenatal and immunization incentive programs, pregnancy and childbirth classes, early childhood family education, and stop-smoking classes.

Mayo Health Plan will be responsible for developing and maintaining the provider network and handling care management functions, including coordinating referrals and quality assurance. UCare is responsible for member eligibility and enrollment, customer service, claims processing, and accountability to the state.

Mayo Income from Patient Care Plummets

The Mayo Clinic's net income from patient care dropped 69 percent last year, from $58 million to $18 million, the Mayo Foundation reported. Total income for 1996 was $76 million, down from $299 million the year before. The decline was blamed on the growing impact of managed care plans. Officials said the medical center and its subsidiaries are still "financially strong," primarily because of investments and donations.

"It's not a question of patients wanting to come—we have more than we can handle," said John Herrell, chief administrative officer of the foundation, in a Twin Cities-based *Star Tribune* article. A growing number of patients are covered by Medicare and managed care plans, which cut Mayo's revenues more than expected last year. Herrell said Mayo hopes to offset the trend with a modest reduction in expenses. A 1 percent cut, for example, would double profits.

InterStudy Releases HMO Directory, Report

Nationwide, HMOs added more than 9.9 million new enrollees in the year preceding July 1, 1996. Meanwhile, enrollment in the nation's 636 HMOs surpassed 63.3 million as of July 1, 1996, representing 24 percent of the U.S. population, according to the semiannual report on the managed care industry, "Competitive Edge," by InterStudy Publications. The report also includes "The HMO Directory 7.1," which profiles every licensed HMO in the United States, and "The Industry Report 7.1," which analyzes patterns in enrollment growth.

On July 1, 1996, 37.1 percent of all commercial HMOs (236 plans) reported offering HMO enrollment to Medicare beneficiaries. The top 25 HMOs ranked by Medicare enrollment accounted for 59.3 percent of all HMO Medicare enrollment.

Medicaid grew 49.5 percent during the same year. One-third

First Call Physicians, Inc.
A Locum Tenens Service
500 Eighth Ave. S.
Buffalo, MN 55313

Clinics/Hospital | **Physicians**

Locums Coverage = Revenue

- Patients falling through the gaps?
- Physician burnout or illness?
- Shortage of physicians?

- Earn more with less time.
- No administrative headaches.
- Malpractice premium paid.

Experience, Service, Honesty
Call (metro) 682-3852
(toll free) 888-682-3852

(You'll be glad you did!)



"The climate is ideal - lots of sunshine and no humidity."
Milton Brinton, M.D.

WASHINGTON

The Wenatchee Valley Clinic, a prominent 140+ physician, multi-specialty group practice in the Pacific Northwest has several practice opportunities throughout its practice locations. **Currently, we are seeking:**

WENATCHEE
• Gastroenterologist • Cardiologist
• Infectious Disease • Physiatrist

OMAK/MOSES LAKE
• Family Practice w/OB • Obstetrician
• Ophthalmologist • Urgent Care
• Dermatologist • General Internist
• Gastroenterologist • Radiologist

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Please send CV to James Brown, M.D. -
P.O. Box 489
Wenatchee, WA 98807
FAX (509) 664-7178
Wenatchee Valley Clinic
see our home page @ http://www.wvc.com

HUDSON PHYSICIANS

FAMILY PRACTICE

Hudson Physicians, a fast-growing primary care clinic located in Hudson, Wisconsin, nestled in the scenic St. Croix River Valley, is seeking physicians to join our group of 12 .

Located 15 minutes from St. Paul, Minnesota, Hudson Physicians offers the best of both metropolitan access and outreach/rural family qualities that enhance both practice and lifestyle.

Excellent salary guarantees, benefits and opportunities.

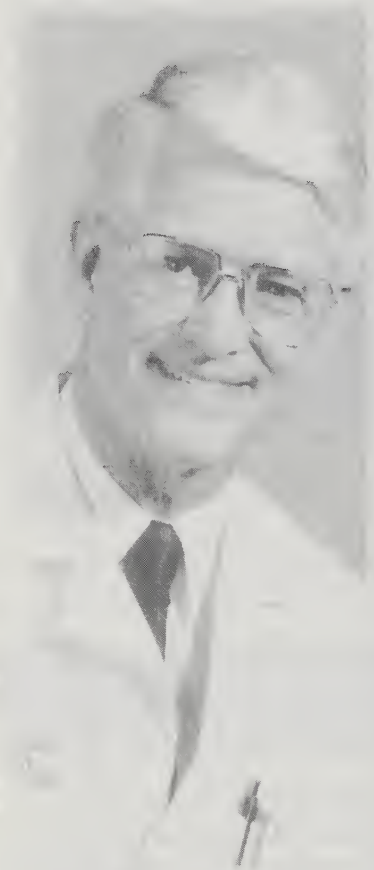
Please contact:
Steven L. Muellerleile, Administrator
Hudson Physicians, Inc.
402 Wisconsin St.
Hudson, WI 54016

HUDSON PHYSICIANS
A division of Western Wisconsin Medical Associates S. C.

(214 plans) of HMOs offered a Medicaid product as of July 1, 1996. The top 25 HMOs ranked by Medicaid enrollment accounted for 46.1 percent of all HMO Medicaid enrollment.

National managed care firms accounted for 79.9 percent of total HMO enrollment as of July 1, 1996.

The top five national managed care firms ranked by total enrollment were Blue Cross and Blue Shield, Kaiser Foundation Health Plans, Inc., United HealthCare Corporation, U.S. Healthcare, Inc., and CIGNA Health Plans, Inc.



"One of the rewards of being a physician is that I accompany my patients through both joyous and painful life experiences. For example, it was especially delightful to deliver the babies of mothers that I had delivered years earlier. More than once, three generations crowded the delivery room.

Death is also part of my profession. It is a painful and difficult time for patients and their families. But it is emotionally satisfying to be able to help my patients, many of whom I've known for years, through the last stage of life.

In any situation, I empathize with my patients. I ask myself how I would feel questioning my physician about similar concerns. I believe if I listen to the patient, he or she will tell me the diagnosis. I am proud to carry on our profession's traditions."

"The practice of medicine has tremendous psychological and intellectual rewards . . ."

Allen Delzell, M.D.
Family Practice
Fridley Plaza Clinic



Medical Research

'U' Study: Exercise After Menopause Lowers Mortality

Women who are physically active after menopause have lower rates of all-cause mortality than their inactive counterparts, according to a study by researchers in the University of Minnesota's School of Public Health. Results of the study—the largest of its kind—were published in the April 23 *Journal of the American Medical Association.*

The seven-year study looked at how frequency and intensity of exercise affected the longevity of 40,417 postmenopausal Iowa women between the ages of 55 and 69 in 1986. Among the findings, women who were physically active outlived those who weren't by more than 2-to-1. "Women don't have to rush out and join a health club to benefit from physical activity," said Lawrence Kushi, Ph.D., Sc.D., professor of epidemiology and lead investigator.

Breast Density, Cancer Risk Genetically Linked

Researchers with the University of Minnesota Cancer Center have found evidence that mammographic breast density, a measure of the relative proportions of fat, connective tissue, and glandular epithelial tissue in the breast that is a strong and independent predictor of breast cancer risk, is genetically influenced. The study, published in the April 16 *Journal of the National Cancer Institute*, also suggests that 12 percent of the population has a mutation to this gene that results in breast density twice that of women without the mutation.

Researchers obtained routine mammograms and a variety of health-related data from 1,370 women from 258 different Minnesota families. The study population included 65 mother-daughter pairs and 275 sister-sister pairs. All of

the women were related, either genetically or by marriage, to an original group of 544 breast cancer patients at the university between 1944 and 1952.

"It isn't known how high breast density increases the risk of breast cancer," said lead investigator Thomas Sellers, Ph.D., an associate professor of epidemiology and associate director of the Cancer Center. "But the risk is considered second only to the risk incurred by mutations in the BRCA1 and BRCA2 genes. The good news," added Sellers, "is that while breast density risk factor is partly genetic, it's also shaped by the environment, and so can be modified."

Vitamin E May Help Fight Alzheimer's

Vitamin E may help prevent the development of Alzheimer's disease by blocking the destruction of brain cells, according to University of Minnesota and Mayo Clinic researchers. They plan to participate in a national study in which vitamin supplements or a placebo will be given for three years to 300 to 400 people who are at high risk of the disease but have no recognizable symptoms.

A study published in the April 24 *New England Journal of Medicine* suggests that Vitamin E does influence the onset of Alzheimer's. The study also shows that selegiline, an anti-Parkinson's drug, was as effective as vitamin E, but the drug has not been approved for treating Alzheimer's and can have severe side effects.

Risk of Dementia Higher in Adult Diabetics

People with adult-onset diabetes mellitus (AODM) have a higher risk of developing dementia later in life, according to a Mayo epidemiologic study reported in the *American Journal of Epidemiology*. Researchers examined medical records of all adults in Olmsted County with AODM over a 14-year period. They identified 101 cases of dementia (77 meeting the criteria for Alzheimer's) among the 1,455 people followed, and found that people with AODM had a 1.66 times greater risk of developing dementia than people without AODM. They also found that men with diabetes had a higher risk of Alzheimer's than men in the general population. The higher risks could be caused by diabetes or could be the result of shared risk factors, including common genetic factors, the researchers reported. MM

The Perfect Fit...

...is a rare find. Fairview Health System represents a wide spectrum of practice and lifestyle options in Minnesota. We will help you locate opportunities that are tailored to fit your needs in communities that match your size.

Opportunities now available in communities large, medium and small (and sizes in between) for...

- **Endocrinology**
- **Family Practice**
- **General Surgery**
- **Internal Medicine**
- **Obstetrics/Gynecology**
- **Orthopedic Surgery**
- **Urgent Care**
- **Urology**

Fairview

Physician Recruitment & Retention Dept.
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454



612-672-2288 or 1-800-842-6469 • E-mail: fhsrecruit@aol.com

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

JUNE 1997

June 11-14 **Fiftieth Anniversary Mayo Interventional Cardiology Symposium** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

June 18-20 **Topics and Advances in Pediatrics** University of Minnesota Continuing Medical Education; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

June 18-21 **Sixty-first Annual Course: Advances in Gastrointestinal and GI Laparoscopic Surgery** University of Minnesota Department of Surgery, University of Minnesota, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

JULY 1997

Jul. 13-19 **Mayo Clinic Internal Medicine Board Review 1997** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jul. 14 **Diagnosing Breast Cancer: A Team Approach to Early Detection** Minnesota Medical Association and Midwest Medical Insurance Company; St. Luke's Hospital, Duluth, MN. CONTACT: Robin Houlihan, Midwest Medical Insurance Company, 6600 France Avenue S, Suite 245, Minneapolis, MN 55435; 612/922-5445 or 800/328-5532.

Jul. 20-22 **Update in Otolaryngology: Head and Neck Surgery** Mayo Foundation; Skamania Lodge, Stevenson, WA. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jul. 24-26 **Management Strategies in Hematology** Mayo Medical Laboratories; Whistler, British Columbia. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 507/284-8599.

Jul. 29-31 **Third Annual Mayo Multidisciplinary Symposium on Platelets, Blood Vessels, Biomaterials, and Transfusion** Mayo Foundation; Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jul. 31-Aug. 2 **Bleeding and Thrombosing Diseases: Back to the Basics** Mayo Medical Laboratories; Rochester, MN. CONTACT: Mayo Medical Laboratories, Office of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/533-1710 or 507/266-4373, or fax to 507/284-4542.

AUGUST 1997

Aug. 9 **Advanced Phacoemulsification Techniques** Phillips Eye Institute; Minneapolis, MN. CONTACT: Leslie Gibson, Phillips Eye Institute, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061; fax 612/870-0315; E-mail gibson@allina.com.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

CONFERENCES

June 23 **Infection Control Lecturers** Hennepin County Medical Center; Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Emerging Infectious Diseases** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., June 15 for August ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

Olmsted Medical Center is seeking BC/BE physicians in family medicine. Great opportunity for well-trained physicians to join a 75-physician multispecialty group in a dynamic, progressive practice. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes 10 branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (*5/96-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

Urgent Care Physicians: Immediate part/full-time positions available at two Convenience Care centers in northwest suburbs of the Twin Cities. Family practice-trained providers sought. Send inquiries to Thomas Evans, M.D., Plymouth Convenience Care, 3900 Vinewood Lane, Unit 16-17, Plymouth, MN 55441; 612/551-0901. (6/94-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Physician Needed to work part time in multidisciplinary clinic. All calls confidential to doctor's private line, 612/889-5973. (6/96-R)

Part-time Neurologist wanted for multidisciplinary office, no call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Urgent Care Physicians: We are a growing urgent care practice looking for BC/BE physicians to work full- or part-time to staff our four clinics. We currently have three locations in the metro area and one location in Mankato and are planning on expanding in 1997. Please contact Cara Auge at 612/593-9818 or 800/511-2820 for more information on joining our growing practice, or send inquiries to 9800 Shelard Parkway, #210, Plymouth, MN 55441. (4/97-R)

Manitowoc, Wisconsin: The Manitowoc Clinic, a member of the Aurora Health Care system, is seeking a general internist to join our 16-physician multispecialty group. Guaranteed two-year salary and excellent benefits package. Contact, or send CV to, James Robinson, Administrator, Box 1270, Manitowoc, WI 54221-1270. Telephone 414/682-8841. 3-7/97

Urgent Care Physicians: Opportunities for BC/BE family practitioners. St. Francis Medical Center in Shakopee, 30 minutes southwest of Minneapolis, is opening an urgent care at the hospital in May 1997. Evening and weekend hours are available for permanent positions or moonlighting. A second location in Chaska, 10 minutes northwest of Shakopee, is opening August 1997. Paid malpractice. Contact Debbie Modder, Allina Health System, Route 81465, 5601 Smetana Drive, Minnetonka, MN 55343; 612/992-3094 or 800/248-4921. 4-7/97

Practice to Take Over: Well-established internal medicine practice in downtown Minneapolis. Large patient base. Well-equipped for internal medicine. COLA-certified laboratory. In-office computerized billing system. Nominal charge for equipment and goodwill. The incoming physi-

Affiliated COMMUNITY Medical Centers, P.A.

Join the security of a large multispecialty group located in Southwest and West Central Minnesota Communities of 3,700 to 19,000. All areas flourish with four-season recreational opportunities, strong economies and excellent education where family and lifestyle are a priority. Outstanding benefits for BE/BC physicians in:

Dermatology	Neurology
Family Practice	Ob-Gyn
Internal Medicine	Orthopedic Surgery

Contact: Janiece Durham
Physician Recruitment Coordinator
Affiliated Community Medical Centers
101 Willmar Avenue SW
Willmar, Minnesota 56201-3591
320-231-6366

cian is expected to be busy from day one. Ideal for new residency graduate who has an ambition to be independent or to start own group. Will introduce. Forward all inquiries to: Minnesota Medical Association, Box 864, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. 4-7/97

Olmsted Medical Center: A 75-physician multispecialty group practice is searching for qualified physicians to complement the emergency medicine staff (variety of shifts available). Our Level II emergency department has an annual volume of 18,000 patients and advanced technology to provide the highest quality care. Excellent salary and malpractice insurance coverage provided. Contact: Lois Till-Tarara, Olmsted Medical Center, 1650 4th Street SE, Rochester, MN 55904; 507/287-2430. *3-7/97

Emergency Medicine: Full-time and moonlighting positions available at Lakeview Hospital in Stillwater, Minnesota. Eight thousand patients per year. Low acuity, excellent back-up and remuneration. Great opportunity for emergency medicine or family practice residents to pick up added income and experience. Also, multispecialty group looking to add third ED/urgent care physician. Contact Tom Monahan, M.D., Stillwater Medical Group, P.A., 612/437-1234. *2-7/97

Luther Midelfort–Mayo Health System: A thriving 160-physician multispecialty clinic and hospital in Eau Claire, Wisconsin, is seeking two BC/BE general internists. Posi-

Neurologist, Oncologist, Urgent Care

There are immediate openings at Brainerd Medical Center for a Neurologist, an Oncologist, and an Urgent Care physician.

Brainerd Medical Center, P.A.
- 35-Physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162 bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota
- Surrounded by the premier lakes of Minnesota
- Located in central Minnesota less than 2 1/2 hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:
- Curt Nielson
  (218) 828-7105
  or (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

Urgent Care

HealthPartners is an organization committed to preventive medicine, health promotion and high quality health care. We are seeking BC/BE Family Practice, and Internal Medicine and Pediatric physicians to work evenings and weekends at our Urgent Care clinics.

The Urgent Care clinics are supported by a 24-hour CareLine that is staffed with specially trained registered nurses. These nurses use a telephone triage system to direct patients and arrange for the most appropriate care. X-ray, lab and pharmacy services are located at each clinic, which are located in Apple Valley, Brooklyn Center, Minneapolis, St. Paul and Woodbury. Physician staffing is based upon specific clinic needs and qualified physicians receive an excellent hourly salary and paid malpractice.

For more information on these positions, please call Laura Gaylord at (612) 883-5453 or send/fax your CV to HealthPartners, Physician Services, 8100 34th Avenue South, P.O. Box 1309, Minneapolis, MN 55440-1309, FAX: (612) 883-5395. You may also e-mail inquiries to: laura.j.gaylord@healthpartners.com. EO/AA Employer.

HealthPartners

HealthPartners' mission is to improve the health of our members and our community

tions are open in the Eau Claire and Chippewa Falls offices. Call of 1:6, competitive compensation and benefits package, and a stable work environment are only a few of the benefits of these positions. Eau Claire is a university community of 60,000 people, 90 minutes east of Minneapolis/St. Paul. Contact Christie Blink at 800/573-2580, or fax 715/838-6688. *3-7/97

Luther Midelfort–Mayo Health System: A thriving 160-physician multispecialty clinic and hospital in Eau Claire, Wisconsin is seeking a BC/BE family practitioner for our Chetek, Wisconsin office. A desire to practice ob/gyn is essential. General call of 1:10 and ob/gyn call of 1:7 is expected. Physicians do not have first call in the ER. A newly remodeled office will be shared with one other family practitioner. Chetek, located 40 miles north of Eau Claire, is in the heart of resort country. Located on a chain of six connecting lakes, Chetek offers four-season recreation for the outdoor enthusiast. For further information, contact Christie Blink, Physician Recruitment Coordinator at 800/573-2580, or fax 715/838-6688. *3-7/97

Wanted: Internal Medicine Specialist to provide medical expertise as an in-house consultant for the Social Security disability program in Minnesota. BC is not a requirement. Must be currently licensed in the state of Minnesota. Located in downtown St. Paul. Work must be provided on the premises. Fifty-four dollars per hour, up to 20-plus hours of work per week available immediately. Great flexibility in work schedule. Free parking in the Robert Street ramp. Excellent working conditions. Very stable work opportunity. Earnings are exempt from the MN-CARE 2 percent provider tax. Please contact William T. Ruhl, Assistant Director, Medical Services, MN Disability Determination Services, Suite 300 Metro Square, St. Paul, MN 55101; 612/296-4419. *2-7/97

Green Bay, Wisconsin–Prevea Clinic: An 80-plus physician-owned, multispecialty clinic is expanding its internal medicine department to meet growing patient base in a 200,000 community with a strong work ethic located in beautiful northeastern Wisconsin. 1:8 call. Contact Karen Van Gemert, 800/236-3030 or fax CV to 414/431-3043. Not a J-1 opportunity. *3-8/97

Medical Office available for rent in St. Louis Park, September 1, 1997. Exam equipment, furniture, x-ray unit, and processor available at deep discount. Call Sheilagh 612/540-0015. *2-7/97

Family Practice: BC/BE to join progressive 31-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographic referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefit package with excellent remuneration. Interested physicians should contact Scott D. Ellingson, M.D., or Janet M. Bergeron, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AOA/EOE. *4-9/97

FAMILY PRACTITIONERS: ARE YOU LOOKING FOR...

A CHALLENGING CLINICAL PRACTICE?

- Join 3 F.P. and 2 N.P. in a clinic with 25,000 annual patient visits
- Financially stable 31-bed hospital, 74-bed LTC, and HH agency
- Access to 26 outreach specialists
- Including Operative, Obstetric and Emergency Services

A GOOD LIFE?

- Working flexible 4.5 day week with 1:4 weekend and night call
- A progressively diverse rural community
- Within two hours of Fargo and Sioux Falls and three hours of Twin Cities
- Recreation: Big Stone Lake, 18-hole golf course, National Wildlife Refuge

A SUPPORTIVE COMMUNITY?

- Community-based Health Care Foundation with $1 million dollars pledged
- Providing competitive package including:
  - Guaranteed starting salary w/incentive
  - Two year housing allowance
  - Educational loan repayments

C.V. in confidence to Fred Peterson, Admin.,
Ortonville Area Health Services,
Ortonville, MN 56278.
Phone: (320)839-2502; FAX: (320)839-2507. EOE.

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 25 member medical staff has openings in the areas of:

Family Medicine — **General Surgery**
Orthopedic Surgery — **Psychiatry**
OB/GYN — **Podiatry**

CHISAGO HEALTH SERVICES
A subsidiary of Fairview

Please contact:
Physician Recruitment and Retention Department
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454
1-800-842-6469

Family Practice Residency Faculty

La Crosse-Mayo (formerly St. Francis-Mayo) Family Practice Residency seeks a sixth full-time physician for the position of Assistant/Associate Director. We are expanding to add three Rural Training Track programs. The La Crosse-Mayo program has a 21-year history of training family physicians and is one of the premiere programs in the upper Midwest. Applicants must be American Board of Family Practice certified and experience in teaching is a plus. Extremely competitive salary and benefit package. Send CV to Thomas J. Grau, MD, Program Director, La Crosse-Mayo Family Practice Residency, 700 West Avenue South, La Crosse, WI 54601 or call Physician Services at 1-800-269-1986.

JUNE 1997 INDEX TO ADVERTISERS

Affiliated Community Medical Centers 62
Air Force Health Professionals–Ft. Snelling 9
Allina 31
Aspen Medical Group 5
Brainerd Medical Center 62
Central Minnesota Group Health Plan 31
Chisago Health Services 63
Fairview Clinic Services 59
First Call Physicians, Inc. 57
Franciscan Skemp Healthcare 64
Gillette Children's Specialty Healthcare 8
HealthEast Capitol Medical Laboratory 55
HealthPartners 14, 51, 62
Hennepin Medical Society 58
Hudson Physicians 57
Medical Protective Company ..... Cover 2
Midwest Medical Insurance Company 3
Minnesota Center for Rural Health 56
Mitchell Clinic 31
MMBR ..... Cover 3, Cover 4, 15, 32
Multicare Associates of the Twin Cities 5
North Memorial Medical Programs 13
Ortonville Area Health Services 63
Park Nicollet Medical Center 51
St. Mary's/Duluth Clinic Health System 51
St. Paul-Ramsey CME 12
Staff Care, Inc. 14
THC Minneapolis 5
Wenatchee Valley Clinic 57, 64
Whitesell Medical Locums, Ltd. 56



"We found a quality of life in Eastern Washington that just can't be beat."
Wallace S. Gibbons, M.D.

GASTROENTEROLOGIST

WASHINGTON - A unique opportunity now exists for a well-trained GI who has skills in therapeutic endoscopy. This new practice at our 19 provider multispecialty clinic in Moses Lake, Washington, has been developed as an outreach program from our central 140 physician group clinic in Wenatchee. Demand for services has reached the point to warrant a fulltime resident gastroenterologist.

The position entails full time GI and sharing endoscopy call with a general surgeon in this lake front community. The clinic has a recently completed ambulatory surgery and endoscopy center with video endoscopy. Samaritan Hospital, a 50 bed acute care hospital with well equipped ICU and endoscopy units, as well as a 24-hour staffed emergency department, is located less than a mile away.

Moses Lake, on the shores of a large recreational lake of the same name, is located in central Washington. The community, recently ranked among the top 100 smaller communities in the U.S., has a population of 15,000 with 60,000 in close proximity. The prospect for growth is excellent in part due to a desirable location with one of the largest airports in the state (site of a major airline pilot training facility) and convenient interstate highway access.

Abundant recreational opportunities exist on and around the lake as well as alpine skiing 65 miles away.

Please send CV to James Brown, M.D. -
P.O. Box 489
Wenatchee, WA 98807
FAX (509) 664-7178
see our home page @ http://www.wvc.com

Wenatchee Valley Clinic



Minnesota Medicine

A JOURNAL OF CLINICAL AND HEALTH AFFAIRS

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE
STACKS JUL 22 1997
REC'D



11968-40922 Exp: 12/1997
Univ. of Maryland
Health Sciences Lib.
111 S. Greene St
Baltimore, MD 21201-1583

Special Report:
CHILD LABOR

Answering the call of
GLOBAL MEDICINE

JULY 1997

A BUSY *Schedule* SENT BOB HOME *Early*



Staffed by over 100 physical medicine professionals alone, our brain injury rehabilitation programs are among the nation's most intensive (and respected). And that aggressive rehab approach can lead to a faster return to independence.

We've treated hundreds of brain injury cases, from coma to community re-entry; our experience helps us spot – and maximize – patient potential. For you, that means better outcomes and lower costs.

So when you need to book the brain injury rehab experts, call us.

We'll always make time for you.

NURTURING HUMAN POTENTIAL

HealthEast Bethesda Lutheran Hospital & Rehabilitation Center

559 Capitol Boulevard St. Paul, MN 55103

1-800-566-2720

http://www.healtheast.org

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover photograph of a vendor in south-central India, by David Parker, M.D., M.P.H. See Special Report, page 10.

DEPARTMENTS

3 ..... Editor's Notebook

4 ..... Letters to the Editor

26 .... Author Instructions

44 .... News Clips

58 .... CME in Minnesota

61 .... Classified Ads

64 .... Index to Advertisers

FACE TO FACE

6 **Mission Possible** ..... Douglas Clement
Medical missions in some of the world's most dangerous regions have redefined "urgent care" for Park Nicollet's Susan Vitalis, M.D.

PERSPECTIVES

8 **A Letter from Tanzania** ..... Mark Jacobson, M.D., M.P.H.
A Minnesota-trained physician shares some of the hopes, joys, and challenges he experiences daily as "Doctor in Charge" of a 100-bed hospital in northern Tanzania.

SPECIAL REPORT

10 **Child Labor: The Impact of Economic Exploitation on the Health and Welfare of Children** ..... David L. Parker, M.D., M.P.H.
An occupational epidemiologist exposes child labor as an abuse of human rights and a practice that poses serious health hazards.

FEATURE STORIES

14 **International Medicine: Outside the Comfort Zone** ..... Miriam K. Feldman
Physicians with a strong spiritual or humanitarian calling find rewards practicing medicine in developing nations despite political unrest, exotic disease, and other dangers.

20 **A Heartening Exchange** ..... Jeremiah Christopher Whitten
Transporting equipment and expertise over great distances, medical teams from Minnesota and Kenya worked closely to establish a cardiac surgery center in Nairobi.

CLINICAL & HEALTH AFFAIRS

27 **Sterilization for Family Planning in a Third World Country** ..... John A. Reichert, M.D., Linda Well Nagel, M.D., and Norman S. Solberg, M.D.

BOOK REVIEW

42 **A Tale of Two Missionaries** ..... Charles R. Meyer, M.D.
"Brothers in Spirit: The Correspondence of Albert Schweitzer and William Larimer Mellon, Jr." tells the stories of two men in pursuit of a common dream.

33 The Monitor

Highlights ..... *Quick guide to 1997 legislative action • MMA Annual Meeting schedule • Viewpoint: Minnesota enacts Patient Protection Act*

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editor
Susan Rodsjo

Consulting Editor
Lenore Franzen

Assistant Editor
Juliet Ramotar

Graphic Designers
Susan Rodsjo
Mike May

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine.* The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/DIAL MMA (342-5662).

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine.* Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1996-97 Officers

President
Raymond G. Christensen, M.D.

President-Elect
Kent S. Wilson, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Paul R. Hamann, M.D.

Secretary
Judith F. Shank, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Anthony C. Jaspers, M.D.

Vice Speaker of the House
Blanton Bessinger, M.D.

Past President
Michael J. Murray, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Kendra Flanagan

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth Crabb, M.D.
Theodore L. Fritsche, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/DIAL MMA (342-5662).

Fax: 612/378-3875.

E-mail: mma@mnmed.org

Web site: www.mnmed.org

A Call to Action

The community medicine rotation in Mayo's internal medicine residency used to include a four-week stint at what was a precursor to today's urgent care center. Walk-in patients with colds and sore throats provided residents a taste of low-acuity outpatient medicine. After 20 years, one patient I saw there lingers in my memory. A 50-year-old woman walked in and said she had passed a worm in her stool. I left the exam room constructing the elaborate workup I would undertake for this bizarre symptom—stool cultures, antibody levels. After all, I was surrounded by the Vatican of high-tech medicine. My attending, coincidentally, was an internist who had spent years practicing at an African mission. After I presented the case with a workup worthy of the Case Records at Massachusetts General, he smiled knowingly and said, "Gotta be ascaris." Ahh, my first lesson in Third World medicine.

This month's *Minnesota Medicine* contains a whole tutorial on the subject. Doug Clement profiles Susan Vitalis, M.D., and her global doctoring. Mark Jacobson, M.D., greets us from Arusha, Tanzania, and offers a glimpse of his work. David Parker, M.D., exposes us to the travesty of international child labor. Miriam Feldman sounds out numerous mission physicians about the risks of serving abroad. And John Reichert, M.D., et al. report on their experience performing laparoscopic sterilization in Nicaragua.

Since Schweitzer, mission doctors have been the stuff of legend—and with good reason. Third World doctoring is hard. The medicine is hard and the life is hard. Trained mostly in technology-stuffed American medical centers, mission doctors daily encounter diseases found in those infectious disease chapters you skipped over in medical school. As Mark Jacobson says, there are zebras in every bed. Like my Mayo attending, Third World docs have to diagnose and treat based more on savvy than serology. Sometimes, good guesses have to be good enough.

The life they choose is at least inconvenient and at most, life-threatening. Daily power failures and questionable water supplies pale next to land mines, political intrigue, and personal health threats. I've always marveled at the bland way many mission doctors describe their malaria attacks like they were merely a bad cold. Raising children in this environment presents perils unimagined by Dr. Spock, whose advice doesn't cover lion attacks or exotic disease. Living and working in the developing countries means getting comfortable with being uncomfortable.



So why do they do it? For some, perhaps, it's a yearning for "something different." But thrill seeking isn't mentioned by our featured physicians, and I suspect most Third World M.D.s wouldn't last long if that was their motivation. For others, maybe it's wanderlust, a yen to see another world and another culture. But this tourist-like incentive won't last, either. Really, the only motive that endures, the drive that keeps them going back, is a calling.

"Third World docs have to diagnose and treat based more on savvy than serology."

Calling is an old, but fortunately not outmoded, concept. The Disciples were called by Jesus. Ministers are called by new congregations. But religion needn't have a monopoly on the idea. Calling is more than pursuing an interest. It is more than getting a good job. It is seeing a need and marshaling your gifts to respond to that need. It is hearing a voice that says "serve" and feeling a spirit that keeps you serving.

For mission folks who are called, spirit gets them there and keeps them there, battling worms, war, and worry, sharing their gifts and reaping the rewards.

–Charles R. Meyer, M.D., Editor-in-Chief



Direct Access to Ob/Gyns Is About Women, Not Turf

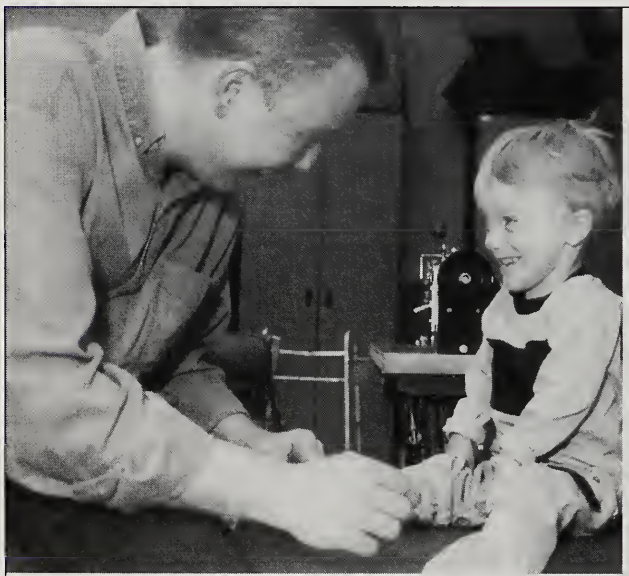
On behalf of the Minnesota Section of the American College of Obstetricians and Gynecologists, I wish to express my disappointment with *Minnesota Medicine* for using the ob/gyns' successful direct access legislative initiative as an example of "physician credibility taking a hit" in your May cover story, "Introspection in the House of Medicine," by Howard Bell. Since we were not given the opportunity to voice our side of the story, I would like to clarify a number of points.

After three years of conducting research, gathering data, meeting with several health plans, meeting with the Minnesota Academy of Family Physicians (MAFP) and the MMA, and listening to our patients' concerns, our organization went to the Legislature as a last resort to remove insurance barriers to direct access to ob/gyn services.

This legislation was consistent with MMA policy (House of Delegates 1995) and was successful in part because the issue was not perceived by women or legislators as a turf battle, but rather one of a woman's right to choose the type of physician that will attend to her most intimate medical needs. To date, 24 states have passed legislation on this issue.

MMA officials asked why our organization paid an outside lobbying firm to represent our interests at the Capitol. We hired our own lobbyists because we saw a conflict of interest in the MMA chief lobbyist's dual representation of the MMA (whose policy supported our position) and MAFP (which clearly did not support us).

Mr. Bell is well-versed on the primary care issue as it relates to ob/gyns (see "Showcasing Primary Care" and "Ob/Gyns Caught in the Middle," *Minnesota Medicine*, October 1995). Our organization sought direct access legislation rather than primary care designation for ob/gyns because most of our members agree that many ob/gyns are not adequately trained



For 100 years, we've been creating new stories every day about our care for kids with chronic conditions.

Since 1897...

Gillette Children's
Specialty Healthcare

An Essential Community Provider

Gillette Children's Mobile Clinics

Two-year old Aric David Cooper receives care from Gillette Children's Specialty Healthcare right in his hometown of Fergus Falls.

Gillette Children's sets up more than 60 mobile clinics each year in cities throughout Minnesota and western Wisconsin to provide the specialized services needed by children with disabilities – right in their hometowns.

For more information, contact Gillette Children's Specialty Healthcare: 1-800-578-4266.

- Cerebral palsy and other neuromotor delays
- Brain and spinal cord injuries
- Complex orthopaedic conditions
- Spina bifida
- Juvenile arthritis
- Epilepsy
- Chronic pain
- Technology dependency (children who breathe on ventilators)

as primary care physicians (as defined by family physicians). However, we are well-trained to provide comprehensive women's health care to our patients, meeting their reproductive and preventive health care needs. Dr. Nicole Lurie's data (N Engl J Med 1993; 329:478-82) suggest we do this more thoroughly than our primary care colleagues. Our point is that women should be able to choose the physician who best suits their needs. Gallop polls have repeatedly shown a majority of women prefer to see an ob/gyn for their reproductive health care needs.

The MMA has done and continues to do valuable work on behalf of all Minnesota physicians. Patient advocacy has long been a priority of the American College of Obstetricians and Gynecologists, and the direct access legislative initiative in Minnesota was an extension of that commitment. On occasion, we must put aside our professional differences in order to do what is right for the patient. To women, direct access to ob/gyn care makes sense. In fact, many women are surprised when they encounter an insurance or gatekeeper barrier to ob/gyn services. There will be other instances when the MMA and ob/gyns will work together to achieve a common goal. However, on this particular issue, the MMA has indeed been "speaking with one voice," and it has been the voice of family physicians.

Janette H. Strathy, M.D.
Legislative Chair
Past President
Minnesota Section ACOG

The Right Care . . . The Right Setting . . . The Right Time



As an extended, critical care hospital focusing on the acutely ill, medically complex patient, THC · Minneapolis aggressively transitions patients to the most appropriate level of care, whether that be a skilled nursing home, subacute facility or home health care. Such was the case with Mr. Ayott, 47 years old, who suffered severe injuries to his chest and lungs in a disastrous car accident. After being stabilized at an acute care hospital, Mr. Ayott transferred to THC to undergo ventilator weaning, wound care, and physical and occupational therapy. With a successful weaning rate of 78% and a new inpatient pulmonary program, THC made it possible for Mr. Ayott to receive the right care in the right setting at the right time.

THC Minneapolis
A Subsidiary of Transitional Hospitals Corporation

612-588-2750

Medically Complex Program · Pulmonary/Ventilator Program
Wound Care Program · Low Tolerance Rehabilitation Services

MISSION POSSIBLE

Medical missions in some of the world's most dangerous regions have redefined "urgent care" for Park Nicollet's Susan Vitalis, M.D.

Douglas Clement

Bosnia, Rwanda, Somalia, Sudan. Over the last five years, these have been among the most dangerous countries on earth. But Susan Vitalis, M.D., a Park Nicollet urgent care physician, has lived, worked, and thrived in each of them, armed with little more than antibiotics and a stethoscope. In the end, it was basketball that brought her down.

"I was in trouble. I felt it," says Vitalis, 35, legs extended across a couch in her modest Minnetonka home, crutches at her side. In June 1996, the former high school athlete tore the anterior cruciate ligament of her right knee during a casual basketball game with fellow health workers and school teachers in Sarajevo during one of her overseas stints. Three surgeries and several complications later, Vitalis is waiting for the knee to heal, appreciating the other end of the physician-patient relationship.

It isn't surprising that it took a leg injury to slow Vitalis down. Since completing her family practice residency at Methodist Hospital in St. Louis Park in July 1990, she has clocked a total of 16 months in five different countries as a volunteer physician, largely under the auspices of the World Medical Missions, the medical branch of Samaritan's Purse, an interdenominational Christian missionary group.

Vitalis's father is a retired Lutheran pastor, her mother a nursing instructor, and her grandparents had a strong interest in mission work. "That sifted down to me," says Vitalis. "When I was in grade school, I remember being really moved by things I saw about Africa, and by missionaries who had come back from overseas." Valedictorian and top athlete of her senior-high class in Fargo, North Dakota, and summa cum laude graduate in biology and chemistry from Concordia College in Moorhead, Minnesota, Vitalis graduated from Johns Hopkins School of Medicine in 1987. She considered specialties in ophthalmology and pediatrics but chose family practice "because of its broader spectrum and greater flexibility."

In 1990, she began her first tour of medical duty overseas in rural western Kenya at the remote 299-bed Tenwek Hospital. "We flew in and landed in a dirt field,"



Susan Vitalis in Ulang, a village in southern Sudan.

she recalls. And from then on, things couldn't have been more different than at Methodist. Equipment was scarce, old, and ill-functioning. Diseases she'd never seen before were common. In three months, she treated 200 cases of meningitis. And by the time she returned to Minnesota to begin work at Park Nicollet's Urgent Care Clinic, the world had changed.

Or rather, Vitalis had. "It was hard to relate to things here for a while," she recalls. "I had been through so much, and I had changed and learned and grown. I came back and everything was the same as when I left, but I was so different." Culture shock upon return is often strong, and for those who travel to poor countries, the shock of abundance back home can be especially difficult. "It was hard to walk into a grocery store here and not think about all the people who were struggling just to grow enough food in Kenya."

The experience also changed Vitalis's approach to medicine. "Working overseas forces you to get much better in your physical exam," she contends. "You have to concentrate on listening to the lungs, for example, because you can't just send someone for a chest x-ray."

Her coworkers observe that Vitalis also became more attuned to unusual diseases. "For instance, malaria," notes Linda Peitzman, M.D., associate medical director for HealthSystem Minnesota and former chair of the Urgent Care Department. "We rarely see it, and she is more apt to pick up on it, particularly for travelers who are coming here from those areas [with high rates of infection]."

Vitalis's next trip abroad was a six-week tour in Somalia, starting in March 1993. She and a small medical team provided mobile medical clinics in and around Mogadishu. "We set up the clinics every day, would see whoever came, and then pack up and go home," she says. There, as in Kenya, Vitalis found herself the object of considerable awe. The blond-haired, blue-eyed doctor was an oddity, and children would follow her constantly. At the mobile clinic, her patient waiting line would often be the longest. "It was getting to be kind of a problem," says Vitalis, so she asked her translator for an explanation. "He said, 'Well, they've heard that the white doctors are so good, and you're the whitest of the white.' "

Vitalis returned to the States for the summer, back to her urgent care work at Park Nicollet. With its wide range of patients and illnesses, it's perfect for Vitalis. "There's always a little bit of unpredictability," she says. "I like the diversity and the excitement of not knowing what's going to come in the door next."

Park Nicollet has been very supportive of Vitalis's frequent sojourns. "The people I work with are fantastic," says Vitalis. "They're very understanding, helpful, and flexible when it comes to my taking leaves of absence."

Peitzman explains that Park Nicollet actually benefits from Vitalis's good works. "Frankly, it helps us all feel better. We can do missionary work through her. And

VITALIS continued on page 50

A Letter from TANZANIA

A Minnesota-trained physician shares some of the hopes, joys, and challenges he experiences daily as "Doctor in Charge" of a 100-bed hospital in northern Tanzania.

MARK JACOBSON, M.D., M.P.H.

Dear Colleagues:

Greetings from Selian Lutheran Hospital in the Maasai Highlands of northern Tanzania. As I begin to write, I recall the expanse of my experience as a doctor in Africa for more than a decade. Life and medicine here are often frustrating but never boring, offering a panorama of opportunities to serve, love, heal, and learn. The challenges are equally broad, sweeping across the worlds of medicine, politics, economics, anthropology, and religion.

Here in Africa, the unusual is the norm. We often say, "When you hear hoof beats, think zebras!" We've also found that seeking one diagnosis to explain all the patient's symptoms is usually the wrong approach. Patients presenting to Selian most often have a multiplicity of pathologies. Consider some of my current patients: a man suffering from relapse of trypanosomiasis due to incomplete initial therapy (he actually presented for acute malaria); half a dozen HIV-infected men with concomitant tuberculosis; an elderly man with a TB pericardial effusion; an 11-year-old Maasai boy suffering from scurvy; three pediatric orthopedic patients needing correction of tibial bowing secondary to fluorosis; a woman with an ascending paralysis presumably due to HIV-related CMV polyradiculoneuropathy; plus an assortment of run-of-the-mill pneumonias, malaria, and gastroenteritis.

And the unusual gets even more unusual! The people who run safaris talk of the "big five"—those most dangerous of the dangerous animals: elephant, rhino, buffalo, leopard, and lion. At Selian, we recently had a run of patients we dubbed our own "big five," all victims of animal attacks: a man who had a run-in with a lion and was bitten from one side of his head to the opposite shoulder; a man gored by an elephant tusk; a boy thrown into a tree by a buffalo; a Maasai warrior who put his hand between one of his cows and a leopard; and a pregnant woman who nearly lost her elbow to a hyena while urinating, as pregnant women so often do.

And while the medical challenges have been invigorating, so, too, have the nonmedical. In supervising the building of Selian Hospital, I have become a mechanic, building contractor, and handyman—I can plumb with the best of them.



Mark Jacobson administers eye drops to a child who could not open his eyes because of mucus. The infection was caused by disease-carrying flies.

PATIENT CARE

Selian Lutheran is a 100-bed hospital near the city of Arusha in northern Tanzania. I serve as the "Doctor in Charge," or medical director, for this institution, which consisted of only a 10-bed dispensary when I arrived 11 years ago. Now we serve 40,000 patients a year and run at 100 percent occupancy. We are a team of four doctors and 10 clinical officers, medical auxiliaries with three years of medical training.

One of our practice's more dramatic successes—and most striking to the medical students and volunteer doctors who spend time at Selian—is the quality of care we provide despite the limited technology. We have access to basic radiology (meaning regular films of the chest, abdomen, extremities, and skull). Ultrasound capability has dramatically improved quality of care. We have a lab with basic hematology, limited microbiology, a bit of serology, and much experience in parasitology. But we have no electrolytes, almost no chemistries, and coagulation tests are a thing of our dreams. Nonetheless, our hospital mortality rate averages only 5 percent of admissions—remarkable considering the high number of HIV-positive patients presenting on our wards.

HIV and AIDS are having a growing impact on our practice of medicine. One-third of our admitted patients are HIV positive, and at any one time, we work with a dozen patients with AIDS complications. We treat their major complaints—TB, diarrhea, and thrush. Little more is possible. We focus on the patients' futures and the goal of "living positively" with HIV as we try to get them out of the hospital and into home-based care provided by their families.

Medical and surgical pathology, often advanced upon presentation, are cause for both distress and hope. We feel hopeful in that much of what we see is infectious disease. Our hospital can serve many of these patients well and restore them to health. Pneumonia and malaria alone account for 65 percent of our hospital admissions. But daily we confront advanced pathology for which we can do little. Congestive heart failure due to congenital defects or rheumatic heart disease is most distressing, as we know they could be corrected in a different economic and medical environment. Even more disturbing is the realization that so much of the pathology could be prevented and its effects muted if acted upon earlier. This is what leads me out of the hospital and into the community. This is what opens the panorama of opportunity to learn and to serve—to explore the anthropological and spiritual underpinnings of illness and health, to struggle against the economic and cultural oppressions that give rise to ill health, and to seek economically viable approaches to healing in a developing economy.

HEALTH, HEALING, AND WHOLENESS AMONG THE MAASAI

I have the good fortune of serving the Maasai, one of the more traditional and better-known tribal

JACOBSON continued on page 51

The Impact of Economic Exploitation on the Health and Welfare of Children

CHILD LABOR

Text & photographs by David L. Parker, M.D., M.P.H.

During the last six years I have traveled extensively worldwide, learning about and photographing child labor.

In my travels outside the United States, I have visited well over 500 factories, dozens of garbage dumps, farms, restaurants, markets, stores, and hotels. I have even been thrown out of brothels.

continued



Vendor in south-central India, 1995



Pumice worker in Lumbok, Indonesia, 1995

I have reached a few conclusions as a result of my work:

- For hundreds of millions of children, work is an abuse of basic human rights;
- The global community is doing far too little to ameliorate this problem;
- Child labor is closely linked to the education of women and women's rights; and
- The availability of good schools and free breakfast, lunch, and books would go a long way toward resolving the problem.

Social policy questions concerning child labor are neither unique to the current era nor to the Western world. The earliest known regulation of child labor dates to 1284, when a statute forbade Venetian glassmakers from employing children in certain dangerous aspects of the glass trade.[1] Efforts at reform have been and continue to be impaired by a lack of substantive data on the effects of child labor on health and development.[2] After telling the tragic story of Iqbal Masih, a child worker from Pakistan, this article defines child labor, discusses its prevalence, and identifies the health effects of child labor in developing nations.

The Story of Iqbal Masih

The sad but familiar story of Iqbal Masih of Pakistan serves as a cogent example of child exploitation and the abuse of human rights. His story is by no means unusual. I have visited many factories where children are treated no better than Iqbal.[3]

At the age of 4, Iqbal, the child of a poor farm family living near Lahore, Pakistan, was sent to work in a carpet factory. He was to be paid 3 cents per day for his work. The money was to be used to pay back a $16 loan the factory owner had made to his family. Iqbal's entry into the workforce coincided with a rise in demand in the United States and Europe for hand-knotted carpets. For six years, Iqbal was hunched over a loom and forced to work long hours. He worked side by side with 20 other children knotting carpets from 6 a.m. to 7 p.m., then spent up to two hours cleaning the shop and loading finished carpets for shipment. Talk was prohibited, and the children were allowed one 30-minute break for lunch. If they took longer, they were punished.

Punishments were doled out in a small closet. Children were caned and lashed or hung upside down by their ankles. On a typical day, four children were beaten or punished. On one occasion, Iqbal escaped and went to the police. He was returned to the shop, and the owner was advised to chain him to the loom.

In September 1992, Essan Ulla Khan, director of the Bonded Labor Liberation Front of Pakistan, spoke in a village near Iqbal's home. Iqbal pushed his way to the front of the crowd and asked if he could leave his master and go to school. Encouraged by his encounter with Khan, Iqbal returned to the factory the next day and declared that his debt was void and that he would no longer work. His master responded by dragging him into the courtyard and severely beating him. At the time he received his freedom, Iqbal was told he owed $409. Before he left the village, the workers told Iqbal he had made an enemy of one of its most powerful men. Iqbal responded, "I am not afraid of the carpet master. He should be afraid of me."

Khan later said of Iqbal, "He was the most determined individual I had ever met. He spoke with eloquence and intelligence. You couldn't but be moved when he said the carpet master had robbed him of his childhood."

In 1993, carpet exports to Europe and the United States fell sharply. Iqbal was singled out by the Pakistan Carpet Manufacturers as "the child whose testimony [was] most objectionable and therefore most damaging to the carpet industry." He traveled around the world speaking against child slavery. In 1994, Iqbal was honored by Reebok when he received the International Human Rights for Youth in Action Award.

In April 1995, at the age of 13, Iqbal was killed while he was walking to his Pakistani home with his family. More



Garbage pickers in Bikasi, Indonesia, 1995

than 50 human rights groups condemned the police investigation of his death as "shoddy," "inept," "corrupt," and "tainted." The stones that cover his grave were made by children in a nearby brick factory.



Brick workers near Madras, India, 1995

Child Labor Laws

International law provides a clear and generally accepted consensus on the nature and definition of child labor. In 1919, the first meeting of the International Labour Office (ILO)* fixed a minimum age of 14 for the employment of children (Minimum Age Convention of 1919, no. 5).[4,5] Subsequently, the ILO has adopted many international conventions and regulations. Slavery and bonded labor are prohibited under the ILO Forced Labour Convention of 1930 (no. 29).[4-6]

The most recent of these is the ILO Minimum Age Convention of 1973 (no. 138).[4,5] According to Article 3, "National laws or regulations of the competent authority may, after consultation with the organizations of employers and workers concerned, where such exist, authorize employment or work as from the age of 16 years on conditions that the health, safety and morals of the young persons concerned are fully protected and that the young persons have received adequate specific instruction or vocational training in the relevant branch of activity."[4,5] The 1973 convention allows for a minimum age of employment of 14 for "nations whose economy and educational facilities are insufficiently developed."[4] Recommendation 146 states, "Where the minimum age for admission to types of employment or work which is likely to jeopardize the health, safety, or morals of young persons is still below 18 years, immediate steps should be taken to raise it to that level."[4,5]

The right of children to an education and freedom from exploitation are also clearly stated in the Convention on the Rights of the Child adopted by the U.N. General Assembly on November 20, 1989.[4] This declaration represents a commitment on the part of member nations to work toward a future in which the rights of all children are respected. Additionally, many nations have set a minimum age for employment. Thus, the employment of children is against both internationally accepted law and national laws. Together, these laws lessen the impact of protests from various governments that say linking the control of child labor to

*The International Labour Office, based in Geneva, develops international occupational health standards.

CHILD LABOR continued on page 52

International Medicine: OUTSIDE *the* COMFORT ZONE

By Miriam K. Feldman

Physicians with a strong spiritual or humanitarian calling find rewards practicing medicine in developing nations despite political unrest, exotic disease, and other dangers.

Sally Trippel, M.D., has practiced medicine where clean water doesn't flow from taps or electricity surge at the flick of a switch—where doctors routinely treat diseases they might not ordinarily encounter: cholera, intestinal parasites, malaria, Chagas' disease.

Trippel, an internist in the Department of Internal Medicine and the Division of Preventive Medicine at Mayo Clinic, was in Zaire in 1976 as a Peace Corps staff physician when the first outbreak of Ebola hemorrhagic fever was identified. A few years later, she was in Sierra Leone conducting research on Lassa fever for the Centers for Disease Control and Prevention (CDC). Conditions at Sierra Leone's small mission hospital were ripe for contagion. Lab technicians worked with blood and body fluid specimens on open countertops—a far cry from their colleagues at the CDC in Atlanta, who don space suits before entering the lab. Trippel understood the risks. "I realized I could spend the whole time hyper and paranoid about this," she says, "or I could just relax and not worry about it." She stopped worrying.

Reflecting on her experiences, Trippel says the rewards far outweighed the risks. She went to Africa for the chance to work in a developing country where she could apply both her medical and public health training. She got it. She also learned that much can be accomplished with little technology. And she learned about herself. "I grew up," says Trippel.

Talk to any number of physicians who have done international health work and the stories are similar. Working in a developing country can be risky business, they say. The risks go far beyond disease. Political unrest, rebel fighting, coups, land mines, accidents, depression, and alienation all come with the territory.

Health care workers are certainly not immune to any of the dangers, including political violence. This past May, for example, the *New York Times* reported that a Zairian rebel unit had entered a hospital and seized about 50 Hutu children who were being treated for malnutrition. The rebels also kidnapped 60 adults and severely beat two nurses and a health assistant who tried to intervene.

But in spite of the many risks and dangers, vast numbers of physicians accept assignments overseas. While nobody tracks the exact number, the Ameri-can Medical Association's Office of International Medicine estimates that hundreds of organizations send thousands of physicians abroad every year.

What motivates physicians to leave their comfortable posts for unknown, often dangerous assignments? "Most of the people feel called to do some kind of international health work," says Patricia Ohmans, who coordinates an annual 12-week orientation course for Minnesota International Health Volunteers (MIHV). Physicians who don't have a calling—whether spiritual or humanitarian—ought to stay home, she advises. "If you're going to disrupt

your life, you'd better know why you want to do it."

Physicians who have done international health work agree it requires strong faith or drive. "If I didn't have that calling, I doubt very much that I ever would have done this," says Susan B. Johnson, M.D., a Minnesota native who has been to Africa numerous times with her husband, Royce Johnson II, M.D., and their four children, one of whom contracted malaria.

"It's comfortable in the United States," says Johnson, who took her first trip to Africa when her oldest child was 2. "International work takes a lot of effort. It's stressful." The Johnsons, ophthalmologists in Rogers, Arkansas, made their trips fully aware of the risks. One cousin had died of malaria while on a mission to Africa. "It does happen," Susan Johnson acknowledges. "You know you're taking a risk, but you take it because you feel a calling to do what you're doing."

Gary Hipp, M.D., is president of the Bloomington-based Mission Moving Mountains, which has more than 40 missionaries in East and West Africa at any given time. Hipp spent eight years in Uganda and Kenya with his family and has made several shorter trips as well, starting when his daughter was just 9 months old. The entire Hipp family has had malaria at least a couple of times. And last fall, Hipp was caught in the crossfire during a 24-hour gun battle that erupted between mercenaries and government troops in Gambia. Friends of his have been hijacked, robbed, even killed. Hipp knows the dangers.

But Hipp has a calling that sustains him. "The call has to be definite," he asserts, but it does not have to be religious. What's needed to serve in an international setting is drive coupled with compassion. "If physicians think, 'This would be nice to try, or an adventure,' that will not sustain them through the difficult times. But if they have a deep commitment to sharing their skills with those less fortunate, that can see them through and help them persevere."

Like Trippel, Hipp says he doesn't dwell on the



PHOTOGRAPH BY SUSAN VITALIS

Patients wait in line at a mobile mission clinic in Mogadishu, Somalia, 1993.



PHOTOGRAPH BY SUSAN VITALIS

Mother and son wait to be treated at a mobile clinic in Mogadishu, Somalia.

risks. "We probably only think about them when they're happening around us," he says. "Less than 2 percent of your time is spent thinking about it in the course of the year."

Still, when you're in a dangerous situation, you can't help but be thankful when you come out alive, as Susan Vitalis, M.D., understands all too well. She was in a small village in Sudan when a rival tribe entered and started shooting (see Face to Face profile of Vitalis, page 6). Vitalis and other members of her mission group hid out in a bomb shelter for three hours until a U.N. group arrived by helicopter for an evacuation. "That was the time I most felt that I could just as easily die as I could get out," says Vitalis, who is an urgent care physician at Park Nicollet Clinic.

Land mines are another hazard. One worker for the American Refugee Committee was killed and another lost both legs when the jeep they were driving hit a land mine in Zaire, Ohmans reports. Land mines are also a concern in Honduras, where Marianne Serkland, M.D., a cardiologist at Central Minnesota Heart Center, St. Cloud, spends periodic two-week stints with the Minneapolis-based International Health Service. Serkland has worked in areas where nobody dares wander outside the village because of land mines left by Nicaraguans and the U.S. military.

Travel in Honduras poses other challenges, as well. Serkland has been to places that can only be reached by canoe. And she recalls flying to remote areas where the airstrips are shared by cattle. Planes buzz the airstrip to scatter the herds before landing.

The threat of land mines, tribal battles, and exotic disease cannot be minimized, but the greatest dangers are, surprisingly, far more mundane. Poor roads, vehicles in disrepair, and wandering animals all contribute to the risk of car and motorcycle accidents, which are the biggest threats to volunteers, according to a Peace Corps study.

As for disease, the risks are greater for contracting a sexually transmitted disease, or even AIDS, than some rare condition. As Ohmans explains, international workers are likely to be lonely; they're meeting new people and may be making romantic liaisons they wouldn't make at home. "So the diseases they might contract are a little more pedestrian than cholera or malaria."

Neal Holtan, M.D., who founded the International Clinic at St. Paul-Ramsey Medical Center in 1980, lectures on psychological adjustment and culture shock for Ohmans' 12-week course. Overseas workers often experience severe anxiety, says Holtan, who has worked in Uganda and Thailand. "If you're not anxious, there's something wrong with you."

continued on page 18

Preparation, Precautions, and Advice

If you are a health care worker who feels called or otherwise motivated to volunteer your medical expertise in a developing country, consider the following before packing your bags.

• *Check out the organizations that offer international opportunities.* "A person exploring overseas opportunities should ask what kind of security guidance they give their employees and the precautions they take with their staff," advises Judy Marcouiller, director of human resources and administration for the American Refugee Committee (ARC). Different groups take different views toward their employees' personal safety. Samaritan's Purse, an interdenominational Christian mission organization, and ARC are conservative when it comes to ensuring their workers' safety. Other groups send volunteers anywhere there's a need.

If you feel drawn to volunteer overseas, find a place that "isn't so hot," says Susan Vitalis, M.D., an urgent care physician at Park Nicollet Clinic. "Not everybody can go into a place where there is political turmoil and feel at rest enough to be productive," she says. Vitalis (see profile, page 6) has made several medical missions to Africa with Samaritan's Purse. "Later, if you want to go to a place with political unrest, you at least have dealt with some of the other issues."

• *Find out how well you will adapt to another culture.* Gary Hipp, M.D., president of the Bloomington-based Mission Moving Mountains, administers a cross-cultural adaptability test to potential volunteers. The test helps determine an individual's flexibility and ability to perform in a cross-cultural setting.

"Even more important than health care workers' medical skills is their ability to function in another country," says ARC's Marcouiller. "You have to have those skills and the ability to be sensitive to another culture in order to cope and to perform appropriately."

• *Take necessary precautions.* Perhaps the most obvious precaution is getting the proper immunizations. Purifying water and avoiding tainted food are also a must.

Equally important, but perhaps not as obvious, is the need for cultural sensitivity. As guests in another country, U.S. health care workers must be circumspect, advises Patricia Ohmans, who coordinates a 12-week course for potential international health care workers. For example, physicians may discover that a tannery has been polluting the river water, and they may want to speak out. Be careful, warns Ohmans. "Medical workers in many developing countries are targeted by repressive governments, so trying to attack a water pollution problem may get them into trouble in ways they can't imagine."

Similarly, Neal Holtan, M.D., founder of the International Clinic at St. Paul-Ramsey Medical Center, cautions against being naive. "We're so sheltered from what is commonplace in some parts of the world," he says, citing political instability, paramilitary organizations, and groups of individuals that answer to no one. "That shouldn't stop anyone who has the drive to go. Common sense is the key," says Holtan, who also is medical director of the St. Paul-Ramsey County Public Health Department.

• *Consider staying put.* After weighing the risks and benefits, some physicians may decide to practice cross-cultural medicine right here in Minnesota, where immigrant populations from around the world are increasing. "You don't have to go to East Zanzibar," says Ohmans. "One of the sessions in my course addresses why health care providers *shouldn't* go overseas because there's so much work they can do right here."

Physicians can work in community clinics like the Pilot City Health Care Center in north Minneapolis or the Model Cities Community Clinic in St. Paul, which treat patients from Thailand, Laos, Vietnam, Cambodia, Ethiopia, Somalia, and Sudan. The Olmsted County Public Health Department's Refugee Health Clinic serves patients from Vietnam, Bosnia, Russia, and Somalia. Or doctors can choose from any number of volunteer and paid opportunities on Native American reservations.

All of these patients have special health care needs. "[Refugees] are not leaving their health problems behind, for the most part, or the mental health problems that accompany war, stress, and relocation," says Ohmans. "Minnesota offers lots of opportunities to help refugees once they've settled here." *–MKF*

Hipp has seen the psychological problems escalate to depression, and even suicide, because of the culture shock and social isolation that many workers experience. "Depression is an expected part of the first six to 12 months," he says. "Or what's called 'culture stress' or 'culture shock.' It's normal. If you don't have prefield training, you can have some disastrous results."

Ironically, culture shock can work both ways. Vitalis recalls how difficult her first homecoming was. "I was trying to bring this life over to Africa and the African life over to this life. I almost have to separate myself. This is a different culture. I can't expect people here to understand what I've been through." For that reason, she believes a debriefing is essential. "It's good to talk about it when you get home," she says. "It helps if you go back again. You work through the anxieties you have. You're ready."

Trippel agrees that readjustment can be difficult. "When you come back to the U.S., you suddenly realize you've had a very unusual and intense experience that

Medical Missionary Organizations

A number of organizations recruit health care professionals for volunteer services overseas. The American Medical Association's Office of International Medicine steers physicians to organizations that need volunteers. Physicians who call the AMA will receive tips on where to call, as well as reprints from the August 7, 1996, issue of JAMA, which reports on physician service opportunity abroad. For more information call 312/464-4386. Following is a list of Minnesota organizations recruiting physician volunteers.

American Refugee Committee
2344 Nicollet Avenue
Suite 350
Minneapolis, MN 55404
612/872-7060

Evangelical Free Church of America
901 East 78th Street
Minneapolis, MN 55420-1300
800/745-2202

Global Health Ministries
7831 Hickory Street NE
Fridley, MN 55432
612/586-9590

Global Volunteers
375 East Little Canada Road
St. Paul, MN 55117
800/487-1074

International Health Service
5727 West 36th Street
St. Louis Park, MN 55416
612/920-0433

Mission Moving Mountains
10800 Lyndale Avenue South
Suite 100
Bloomington, MN 55420-5614
612/884-8450

Operation Smile
Minnesota Chapter
PO Box 8776
Minneapolis, MN 55485-8776
612/540-4310

Programa San Francisco de Asis
c/o Plastic Surgery Associates, Ltd.
385 North Lexington Parkway
St. Paul, MN 55104
612/645-3966

United Methodist Short-Term Volunteers in Mission
Rev. Marc Well Nagel
1032 Trenton Circle North
Plymouth, MN 55441
612/544-6389

U.S. Medical Aid Foundation
2261 Lee Avenue North
Golden Valley, MN 55422
612/521-8527

World Mission Prayer League
232 Clifton Avenue
Minneapolis, MN 55403
612/871-6843

you didn't share with your family and friends. ... You don't have very much in common with people who were close friends ... and you go through a feeling of not belonging to your own culture," she says.

Those feelings of alienation can be especially profound for children, says Hipp, who plans to take his son to Africa this summer to remind him of where he grew up. Hipp says the term "third-culture kids" has been coined to describe children like his, who have spent most of their formative years in another country. "They're not fully American," he says. "They're not fully Ugandan. They often struggle with how they fit in."

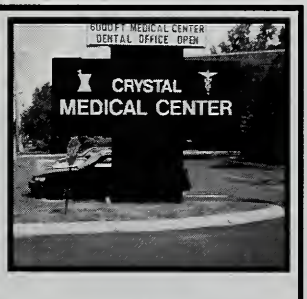
But like adults, children are rewarded with a broader view of the world. Hipp's children appreciate what he calls the "smaller things," and they seem less affected by the materialism of our culture. Hipp says his children know how little some of their African playmates had and yet how happy they were.

Adults come away with a similar appreciation that less can be more. "You learn you can do an awful lot without all of the technology we have in the West," Trippel says. "You learn that you can do a lot with simple health interventions, like teaching people to wash their hands, or about the importance of clean water."

Holtan agrees. "If you have done all your pretravel work and thinking and accept some of these realities, then you should be fine." MM

Mirian Feldman is a free-lance writer in Minneapolis and a frequent contributor to Minnesota Medicine.

Looking for a new place to hang your stethoscope?



For Lease - Medical Office

5640 West Broadway * Crystal, MN

5800 SQ. FT. fully built-out Medical Clinic with:

*15 Examination rooms
*5 doctor's offices
*1 doctor's lounge with bathroom and shower
*X-ray room with X-ray
*5 bathrooms
*Laboratory
*Large reception waiting room
*Large office staff and records area
*Dentist co-tenants

For Leasing info call Richard Jahnke 646-7901 today!

Pastor Enterprises

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 25 member medical staff has openings in the areas of:

Family Medicine **General Surgery**
Orthopedic Surgery **Psychiatry**
OB/GYN **Podiatry**

CHISAGO HEALTH SERVICES

A subsidiary of Fairview

Please contact:
Physician Recruitment and Retention Department
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454
1-800-842-6469

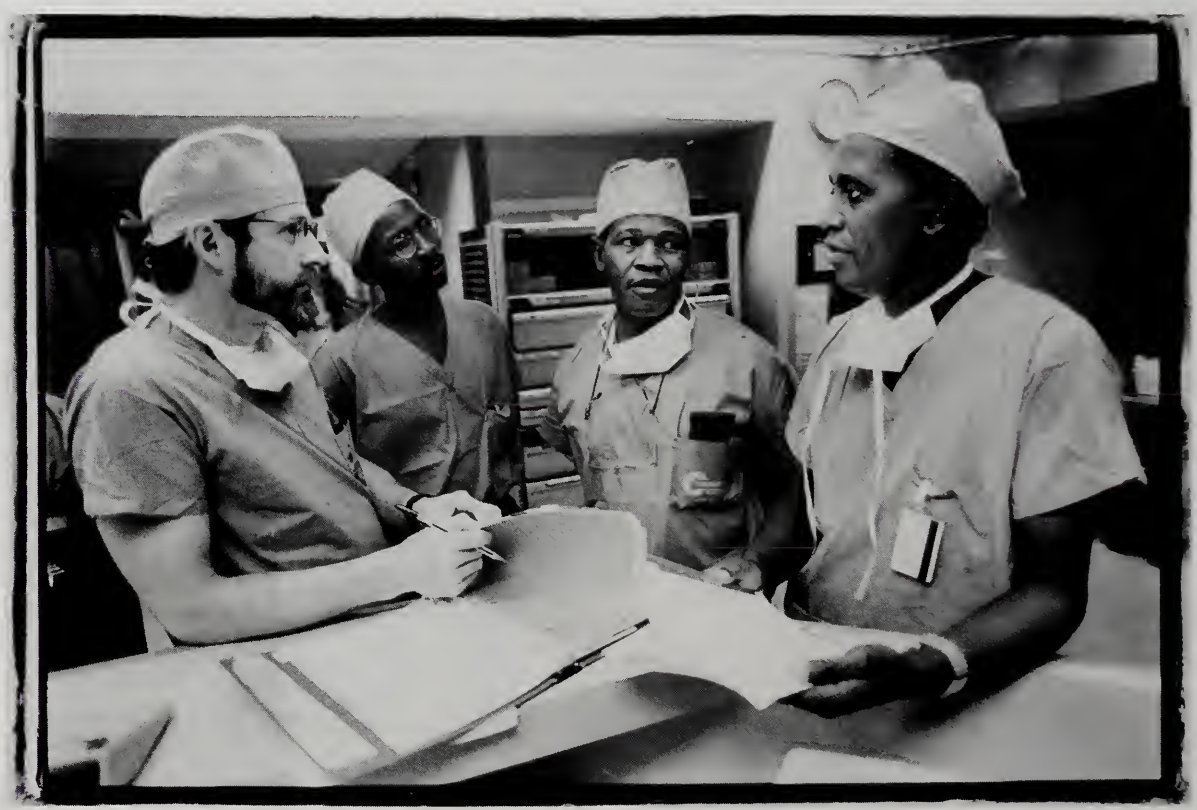
A Heartening Exchange

Text by Jeremiah Christopher Whitten
Photographs by Rob Levine

Transporting equipment and expertise over great distances, medical teams from Minnesota and Kenya worked closely to establish a cardiac surgery center in Nairobi.

History was about to be made. The first coronary bypass operations performed by Kenyan physicians at Nairobi Hospital were scheduled back-to-back. The Kenyan physicians, assisted by a medical team from Minnesota, would perform the surgery on two local patients using diagnostic equipment that just a few years earlier was used on Chicago Avenue in south Minneapolis.

The Kenyan team performed the operation on the first patient, a 45-year-old-woman who told doctors she was proud to undergo surgery at the local hospital. Shortly before the second procedure, however, the next patient, a 73-year-old man who had already received heart catheterization and was ready for surgery, vanished.



Dr. Lyle Joyce works with Kenyan physicians John Kariuki, Alan Kisia, and Dan Gikonyo at Abbott Northwestern Hospital.

The following day, after news spread that the first patient survived, the man reappeared on the hospital doorstep: now he was ready.

The patient's temporary disappearance underscored for the Minnesota medical team one reason for its two-week visit to Nairobi Hospital in May—to help build local confidence in the hospital's developing cardiovascular program. Many Kenyans have a hard time believing they can undergo successful coronary bypass surgery at Nairobi Hospital. There is a lingering perception that patients should leave the country for heart surgery, so most Kenyans who can afford the fees travel to South Africa, India, or Great Britain.



"To think that a nurse and a perfusionist have the same value as a cardiologist is unheard of in some countries. Twenty years ago, we were the same way in the United States."

–Lyle Joyce, M.D.

Establishing a Regional Center

Correcting this misconception among Kenyans was a long process that began years ago in the Twin Cities, thanks in part to Children's HeartLink (CHL), an international medical charity based in Minneapolis that provides treatment for children with heart disease in developing countries.

CHL began its partnership with the Kenyan site in the early 1980s when it sponsored the two-year cardiology training at the University of Minnesota for Betty and Dan Gikonyo, married physicians from Nairobi. It was because of this close Minnesota connection that Nairobi was chosen by CHL as a regional site for a cardiovascular program four years ago. Since then, CHL has sent volunteer medical teams to assist at the site, brought more members of the Kenyan team to Minnesota for training, provided funding for needy children to receive heart surgery at Nairobi Hospital, and provided donated equipment and supplies.

Also with CHL's support, the cardiac catheterization lab formerly in use at Abbott Northwestern Hospital was refurbished and shipped to Nairobi Hospital in December 1995. And last February, the Gikonyos had a homecoming of sorts when their six-person medical team (see page 24 for a list of members) arrived in the Twin Cities for two weeks of training to enhance the team's skills in cardiac surgery, including catheterization procedures.

"In the past few years that Children's HeartLink has been involved in Kenya, we have seen high-quality cardiac surgery being done at the Nairobi Hospital by a talented medical team," says Fern Wilcox, R.N., coordinator of patient treatment and nursing education for CHL. "We provided additional training and equipment, which they wanted to help advance their program to an even higher level."

In May, the volunteer cardiovascular team from Minneapolis traveled to Kenya to follow up on the training done here. They worked side-by-side with their Kenyan colleagues, providing surgical assistance, additional training, and technical support. The team (see page 24) led by Lyle Joyce, M.D., cardiothoracic surgeon with Minnesota Thoracic Group and Minneapolis Heart Institute, also included medical professionals from Abbott Northwestern and North Memorial hospitals.

Such an exchange of medical expertise and equipment required extensive logistical planning, thou-

sands of dollars of donated funds and services, and many thousands of miles of travel. This massive effort to move equipment and know-how across two continents was made so that East African children can stay close to home when they need heart surgery.

Emphasis on Teamwork

Training in the use of certain medical techniques and equipment was an important aspect of the Kenyan group's Minneapolis visit, but the Kenyans had another goal during their trip: to observe how American physicians and medical staff interact as a team.

"The whole purpose of coming here is to gain experience as a team so that when we go back, we don't start as individuals and then try recruiting a team," said John Kariuki, M.D., leader of the Nairobi Hospital cardiac team, during the visit.

"Our nurse has been working with the nurses here in the operating rooms, the anesthetist has been working with the anesthetists here, and the perfusion-

Where the Heart Is

Flying children halfway around the world for state-of-the-art heart surgery makes for good media coverage and fundraising, but transporting equipment and know-how saves more lives. Having learned that lesson, Children's HeartLink (CHL), a Minneapolis-based international medical charity, now moves equipment and expertise rather than children.

Founded in 1969 and led for many years by Minneapolis cardiovascular surgeon Joe Kiser, M.D., CHL spent its first two decades arranging for more than 600 children to undergo heart surgery in the United States. But in the early 1990s, CHL began experiencing diminishing returns, according to John Cushing, director of program services. Although CHL was raising more money than ever, it found itself treating fewer children because of rising costs (despite the fact that most physicians donated their services). All the money and energy poured into each successful visit helped just one child, while hundreds more who also needed heart surgery remained behind.

It became clear to CHL administrators that the most effective way to treat children was to help local physicians establish regional cardiovascular programs, and then send children the short distance to these programs rather than halfway around the world to Minnesota.

The change has resulted in improved outcomes for everyone: children don't have to travel so far to receive treatment; CHL spends its dollars more effectively and helps more children; and local medical teams learn how to develop their own successful cardiovascular programs that benefit children, adults, and their entire communities.

This spring CHL applied its new philosophy in Kenya by bringing a medical group from Nairobi Hospital to train at Minneapolis cardiac centers and later sending the Minneapolis medical team to Nairobi for follow-up support (see main story).

Betty Gikonyo, M.D., a pediatric cardiologist at Nairobi Hospital, says the shift to local cardiac care has wide-ranging effects. "The child is better off in his own environment with his family and the social support he needs. Also, we, as professionals, get the opportunity to carry out the surgery and to practice what we learned as doctors. Instead of one child benefiting, the whole medical team benefits, and it goes beyond that to the people who are caring for the child in the hospital. Employment is created at the hospital. For all the money spent sponsoring that child at home, there is a benefit to the local economy, to the entire community." *–JCW*

ist has been working with the perfusionist," Kariuki said. "I have been working with Dr. Joyce in surgery, observing how things are done here. We hope that when we go back we will be better prepared. This is a team effort."

Joyce agrees that teamwork is crucial to achieving successful outcomes in surgery—a lesson we have learned only recently here in the United States. "To think that a nurse and a perfusionist have the same value as a cardiologist is unheard of in some countries," says Joyce. "Twenty years ago, we were the same way in the United States. We have learned over the last 20 years that the surgeon can't do it alone. If you don't work as a team, you get a bad result."



"The whole purpose of coming here is to gain experience as a team so that when we go back, we don't start as individuals and then try recruiting a team."

–John Kariuki, M.D.

Making History in Kenya

In total, the Minnesota medical team assisted with six procedures in 13 days, including the groundbreaking coronary bypass surgery, the first double valve replacement, and the first tetralogy of fallot (the last two in children).

The hospital's new center was off to a good start, but to be successful, the new cardiac catheterization lab at Nairobi Hospital must be used heavily. "We know from experience that you need a busy program to give consistently good surgical care," says Joyce. "To do half a dozen or a dozen kids a year would not be enough to sustain this program."

By the time the Minnesota team left after two weeks, Joyce was even more confident that the Kenyan cardiac program was established and well on its way to success. Speaking at a ceremony before a large audience that included the U.S. Ambassador to Kenya, Joyce said: "We're confident that the volume in the new cardiac catheterization lab will be great enough that this cardiac team will be as competent as the best of any cardiac centers in the world."

The Minnesota team's commitment to the cardiac program in Nairobi created strong bonds with the Kenyan team, says pediatric cardiologist Betty Gikonyo, M.D.

"Before, Minnesota was just a name to most of the members of the team," says Gikonyo. "But now that we have been to Minnesota and they have come to Kenya, it's like we are not working with strangers; we are working with friends. We relate to each other much more easily as friends and colleagues, and we know that we are working for one common purpose."

Sharing success with their Kenyan colleagues was equally gratifying for the Minnesota team.

"There is a tremendous satisfaction in helping to provide medical care to people who wouldn't otherwise receive it," says Joyce. "We take great satisfaction in our work here in the U.S., but the truth is, if I weren't here, other surgeons could do the work I do.

"But in a Third World country, if you help a medical team get started, then you truly make a difference. We saw that when we met the patients and their families and saw their joy when their surgery was successful." MM

Jeremiah Christopher Whitten is a Minneapolis-based media relations consultant and writer who

CONTINUING MEDICAL EDUCATION

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

AUGUST, 1997

9 ADVANCED PHACOEMULSIFICATION TECHNIQUES
Presented by: Phillips Eye Institute
Location: Phillips Eye Institute, Minneapolis

SEPTEMBER, 1997

16-17 ADVANCED TRAUMA LIFE SUPPORT
Presented by: Allina Health System
Location: United Hospital, St. Paul

19 MIDWEST GLAUCOMA SYMPOSIUM
Presented by: Phillips Eye Institute
Location: Marriott Hotel - City Center, Minneapolis

26 PAIN DISSEMINATION CONFERENCE
Presented by: Allina Health System
Location: Radison Hotel South & Plaza Hotel, Bloomington

OCTOBER, 1997

15 SUDDEN DEATH & ATHLETES
Presented by: Minneapolis Heart Institute Foundation
Location: Hyatt Regency Hotel, Minneapolis

17 ADVANCED LIFE SUPPORT IN OBSTETRICS (ALSO)
Presented by: Allina Health System
Location: United Hospital, St. Paul

For more information, contact
Allina Clinical Education - (612) 992-2424

™ A Trademark of Allina Health System

Visit the Allina CME calendar on our Home Page at http://www.allina.com

specializes in health care issues and high technology.

The Kenyan team: John Kariuki, M.D., cardiothoracic surgeon; Betty Gikonyo, M.D., pediatric cardiologist; Daniel Gikonyo, M.D., adult cardiologist; Alan Kisia, M.D., anesthesiologist; Benson Machua, surgical nurse; and Fred Mwololo, perfusionist (who received an additional week of training at Mayo Clinic in Rochester).

The Children's HeartLink team: Lyle Joyce, M.D., cardiothoracic surgeon with Minnesota Thoracic Group and Minneapolis Heart Institute; Carol Toninato, R.N., C.N.O.R., C.R.N.F.A., operating room nurse, first assistant, Minnesota Thoracic Group; Jim Gayes, M.D., anesthesiologist, Abbott Northwestern Hospital; Karen Stombaugh, R.N., intensive care nurse, North Memorial Medical Center; Deb McConnell, R.N., coordinator-nursing education, North Memorial; Dennis Mills, perfusionist; Bruce Johnson, M.D., cardiologist, Cardiovascular Consultants; Eric Fuller, biomedical technician, San Francisco, California; Hal Leppink, M.D., retired public health officer and CHL coordinator of prevention services; Fern Wilcox, R.N., intensive care nurse and CHL nursing education coordinator; and Katie Regnier, CHL coordinator of communications.

❦ ❦ ❦ ❦

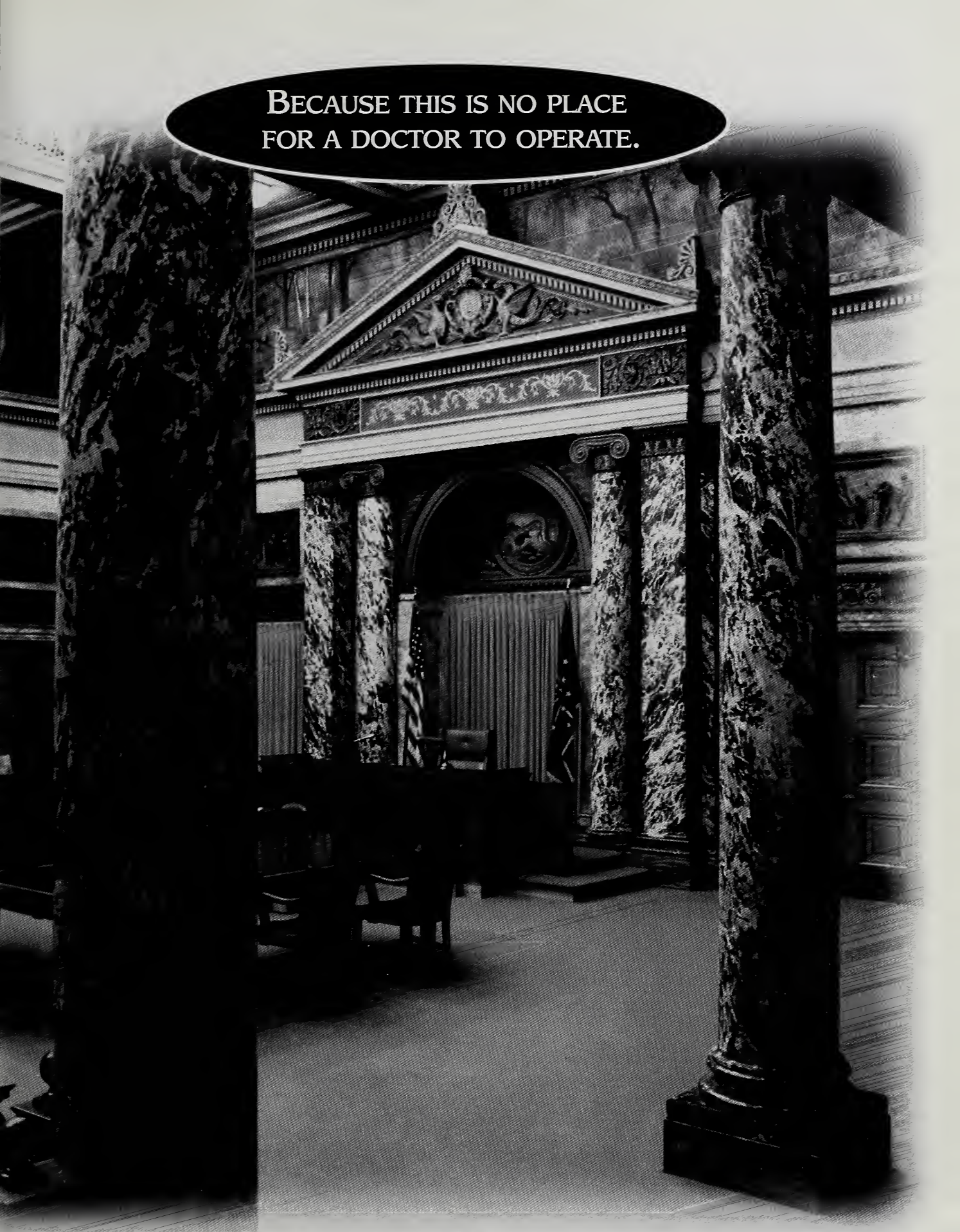
It's 4am.
Time to find the job you want.
Unless, of course, you're too tired to lift a finger.

1·800·233·9330

Researching career opportunities takes time that you don't have. And often when you do, no one else is at work to help you. But the new **Practice Opportunity Line** offers an easy, no pressure, confidential way to conduct the search on your own, 24 hours a day. All you have to do is call, follow the prompts and research the openings. Then send a voice mail mini-resume to the opportunities you wish to pursue. It's fast. It's easy. And you're awake anyway.



The Practice Opportunity Line
We're on call for you.



THE
MEDICAL PROTECTIVE COMPANY ®

Professional Protection Exclusively since 1899

To reach your local office, call 800-344-1899.

GOLD CORPORATE AFFILIATE
MGMA
FOUNDED 1926
PROGRAM UNDERWRITER

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.

3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Sterilization for Family Planning in a Third World Country

John A. Reichert, M.D., Linda Well Nagel, M.D., and Norman S. Solberg, M.D.

ABSTRACT

Outpatient laparoscopy procedures have made sterilization passible for millions of women in developing countries. This repart describes the experience of a team of doctors, nurses, and suppart staff that performed 107 laparoscopic tubal sterilizations during an eight-day sojourn in a remote north-central area of Nicaragua. Minimal analgesia (oral ibuprofen) and anesthesia (1% lidocaine) were used since most of the patients walked to and from the hospital—some up to 15 miles. Because the Nicaraguan government's suppart for birth-control programs is unreliable and because illegal abortion is the leading cause of maternal mortality in Nicaragua, this safe, minimally invasive surgical method is the favored means of birth control.

Laparoscopic sterilization is becoming a popular means of birth control in Third World countries because of its safety, speed, ease of performance, and brief recovery period. The procedure interferes very little with a patient's daily routine. In 1981, Mehta reported on 10,100 laparoscopic tubal sterilizations in rural camps in India and described this technique as safe and valuable for mass sterilizations.[1] Given the hazards of general or spinal anesthesia and the higher morbidity associated with mini-laparotomy and colpotomy, laparoscopy using local anesthesia is the preferred method of sterilization.

This report describes a volunteer medical mission organized through Short-Term Volunteers in Mission. Our group of health care workers offered laparoscopic sterilization in Jalapa, a town in north-central Nicaragua near the Honduran border. The population of this remote town and surrounding area, hotbed of the Nicaraguan civil war, is about 35,000. It is an agricultural community with most employment in tobacco and rice farming. A factory that prepares tobacco leaves for packing and shipping employs some of the inhabitants. However, half of the community is unemployed.

The Nicaraguan government, $17 billion in debt to the World Bank and the International Monetary Fund, is unable to finance consistent programs for family planning. Occasional funding for IUDs or oral contraceptives is short-lived, lasting only a few months at a time. Because of this unpredictable situation, our volunteer group decided to offer something more than a temporary method for family planning. During our eight-day visit we performed 107 laparoscopic sterilizations and 14 vasectomies. In addition, our group fitted more than 450 pairs of donated eyeglasses, saw 163 general medical patients and 125 gynecologic patients, and painted a local schoolhouse. Our team consisted of 16 health care workers, including three obstetrician/gynecologists, one internist, a nutritionist, an optician, several nurses, translators, and other volunteers; all but one were from Minnesota.

Methods

In February 1996 our team initiated a program of sterilization in the town of Jalapa, Nicaragua. By broadcasting our arrival and the procedures we offered over the radio, as well as by visiting factories, cooperative farms, and local gatherings, we interested numerous women in laparoscopic tubal sterilization. The number of vasectomies we performed increased each day until we were doing four procedures per day. Only women and men requesting sterilizations for birth control reasons were accepted. The fact that Nicaragua is principally Catholic (and that the Pope had visited Managua four days before our arrival) seemed to have no effect on our voluntary recruitment of patients.

Women were registered only if they were free of systemic disease and were at least three weeks postpartum. Their age, parity, and their menstrual and obstetric histories were recorded, as well as their means of travel and the time it took to and from the hospital. Two patients had previous abdominal scars, one from a cesarean section and one from abdominal trauma. We performed a mini-laparotomy sterilization on the latter.

Standard medical procedures were modified to cope with the inadequate facilities and the large patient

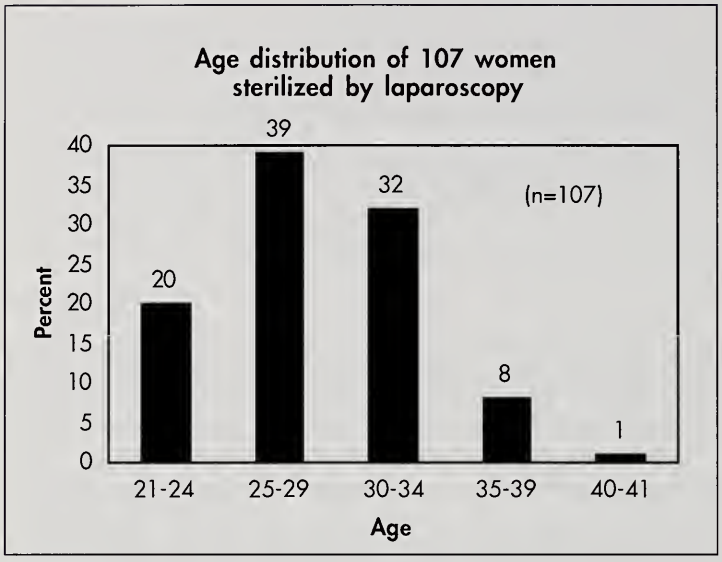


FIGURE 1

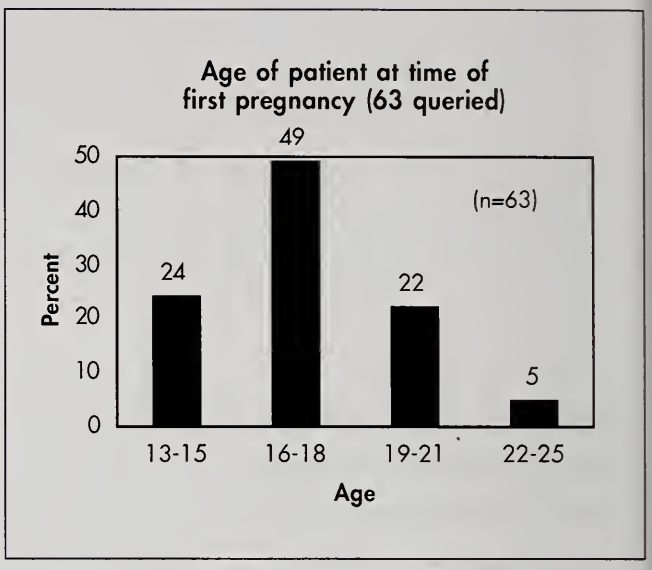


FIGURE 2

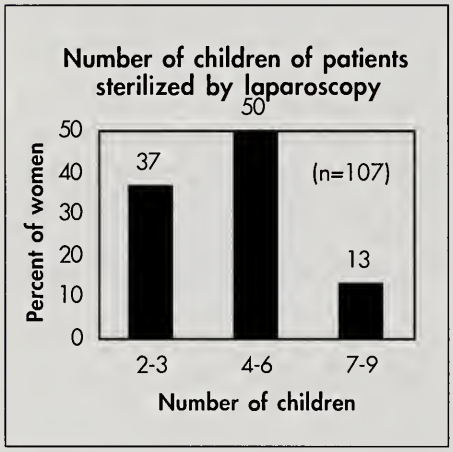


FIGURE 3

load. These modifications were mainly in the areas of decreased sedation/analgesia and length of postoperative surveillance.

All patients fasted for at least six hours before undergoing laparoscopy. We gave each patient 800 mg ibuprofen one hour before surgery and requested that each patient void just before the procedure began. A Betadine prep was used to scrub the abdomen, and a sterile drape was cut along the midline to allow visualization from the umbilicus to the pubis.

We used two laparoscopes (3 mm and 5 mm), a light source, and a laparoflator loaned to us by the Karl Storz Endoscopy company. We also used a multiple placement falope ring applicator and falope rings donated by the Circon instrument company. We washed all instruments in soapy water between cases, soaked them for 20 minutes in Cidex solution, and rinsed them in boiling water, which was changed twice daily. We used sterile gloves for each procedure.

Local anesthesia was administered with 6 cc of 1% lidocaine injected in the periumbilical area, 6 cc in the suprapubic region to a depth of the parietal peritoneum, and 2 cc of 2% lidocaine injected through the falope ring applicator, which was allowed to flow over the grasped segment of each fallopian tube just before placement of the falope ring. We used a Verres needle to create a 2-liter CO_2 pneumoperitoneum, inserted a 3-mm or 5-mm trocar through the umbilicus, followed by laparoscopic placement. The 7-mm falope ring trocar was inserted suprapubically.

The table we used permitted a steep 30° Trendelenburg position, which enabled us to complete the operation without using stirrups or cervical fixation. We used a liberal dose of "vocal anesthesia"—a counselor engaged each patient in continual conversation at the head of the table. This proved to be the single most important aspect of the anesthesia delivered.

After meticulous evacuation of CO_2 from the abdomen, we closed and bandaged the wound. The patient was then moved to a recovery bed and given juice and crackers (some patients were breast-feeding and had gone without food since the night before). Each patient was discharged after 10 to 45 minutes. Patients were instructed regarding wound care, activity, and expected pain and were provided three 400-mg ibuprofen tablets to take every six hours for pain.

Results

Sociodemographic characteristics and fertility profile

The women sterilized ranged in age from 21 to 41 years, with 25 to 29 the most common age group (see Figure 1). The overall mean age was 28.92 years. There were four 21-year-old women who had three to five children each. The age of the women at their first pregnancy varied from 13 years to 24 years, with a mean of 17.36 years. Twenty-four percent of the women were 15 years or younger when they first became pregnant (see Figure 2).

The average number of living children was 4.4, with a range of two to nine children (see Figure 3). Half of the women had delivered a child within the year preceding sterilization, with a mean time of 27 months since last delivery. Thirty-four percent of the women had lactational amenorrhea, and 66% had regular menstruation.

Most of the women walked to and from the hospital for their operations. Seventy-five percent lived in or near the town and walked one hour or less round trip. Another 20%

walked an average of four hours round trip (see the table). The longest distance traveled by foot took 12 hours round trip.

At the time of sterilization, birth control was not well-defined for many women in the group. Two percent of the women used Depo-Provera; 3%, oral contraception; 4%, IUD; 34% were breast-feeding; and more than half the women used either the rhythm method or no birth control (see Figure 4).

Table

Type of transportation to and from hospital and average duration of round trip (n=107)

Type	Number	Percent	Time (hrs)
Bus	5	5	2
Walked (local)	80	75	≤1
Walked (distant)	22	20	4

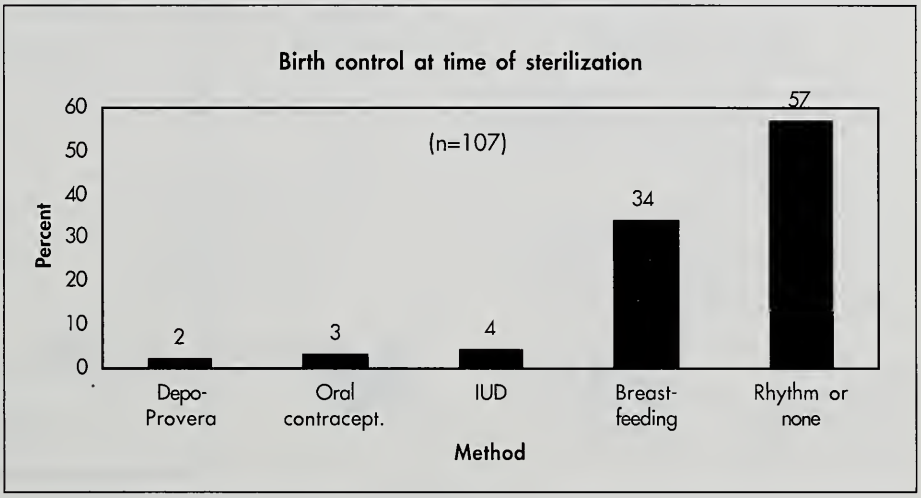


FIGURE 4

Operative complications

Failure to ligate the tubes: We failed to ligate the tubes in three patients. One patient had anticipated a general anesthetic; after discussion, we offered her oral contraceptives and she was dismissed. The second patient experienced extreme anxiety, and we could not complete her surgery without an interpreter. The third patient had subacute salpingitis with marked tubal edema, which made placement of the falope rings impossible; cautery was not available.

Intraoperative pain: The nurse assisting with the surgery recorded her subjective assessment of pain and duration of postoperative recovery for each patient (see Figure 5). More than 75% of the women experienced mild or no pain and were dismissed promptly postoperatively; 20% experienced moderate pain, and 3% experienced severe pain, including the one extremely anxious patient mentioned above (ligation was not completed). Pain dissipated in all patients within 10 to 45 minutes, allowing patients to walk home following discharge.

The length of time from admission to discharge averaged 45 minutes and ranged from 25 to 75 minutes.

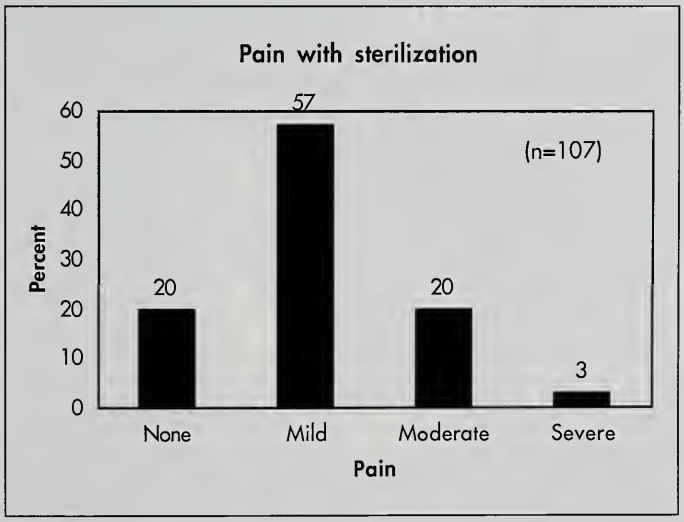


FIGURE 5

Additional diagnoses

We diagnosed umbilical hernias in four patients. We performed mini-laparotomy in one patient because of the size of the hernia and possibility that the intestine was adherent. We also performed a mini-laparotomy on a patient who had undergone previous abdominal surgery for trauma. One patient had an inguinal hernia.

We noted ovarian cysts (4 cm to 5 cm in size and benign in appearance) in two patients and pelvic or abdominal adhesions in six (those with present or past evidence of tubal disease were discharged on a 10-day course of amoxicillin). In one of these patients, we found Fitz-Hugh–Curtis adhesions. We removed IUDs from four patients. The absence of endometriosis was striking; a leiomyoma was noted in only one patient. Three patients experienced transient abdominal bleeding from the omentum or the peritoneal aspect of the incisions, but they did not require therapy. One patient had metrorrhagia while breast-feeding; a urinary HCG was negative, and she was placed on oral iron therapy.

Conclusion

In war-torn Nicaragua, overpopulation and starvation are severe problems, and government support for family planning programs is unreliable. The enthusiasm with which the



"We found a quality of life in Eastern Washington that just can't be beat."
Wallace S. Gibbons, M.D.

WASHINGTON

The Wenatchee Valley Clinic, a prominent 140+ physician, multi-specialty group practice in the Pacific Northwest has several practice opportunities throughout its practice locations. **Currently, we are seeking:**

WENATCHEE

• Gastroenterologist • Cardiologist
• Infectious Disease • Physiatrist

OMAK/MOSES LAKE

• Family Practice w/OB • Obstetrician
• Ophthalmologist • Urgent Care
• Dermatologist • General Internist
• Gastroenterologist • Radiologist
• Nephrologist/I.M.

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Please send CV to James Brown, M.D. -
P.O. Box 489
Wenatchee, WA 98807
FAX (509) 664-7178
Wenatchee Valley Clinic
see our home page @ http://www.wvc.com

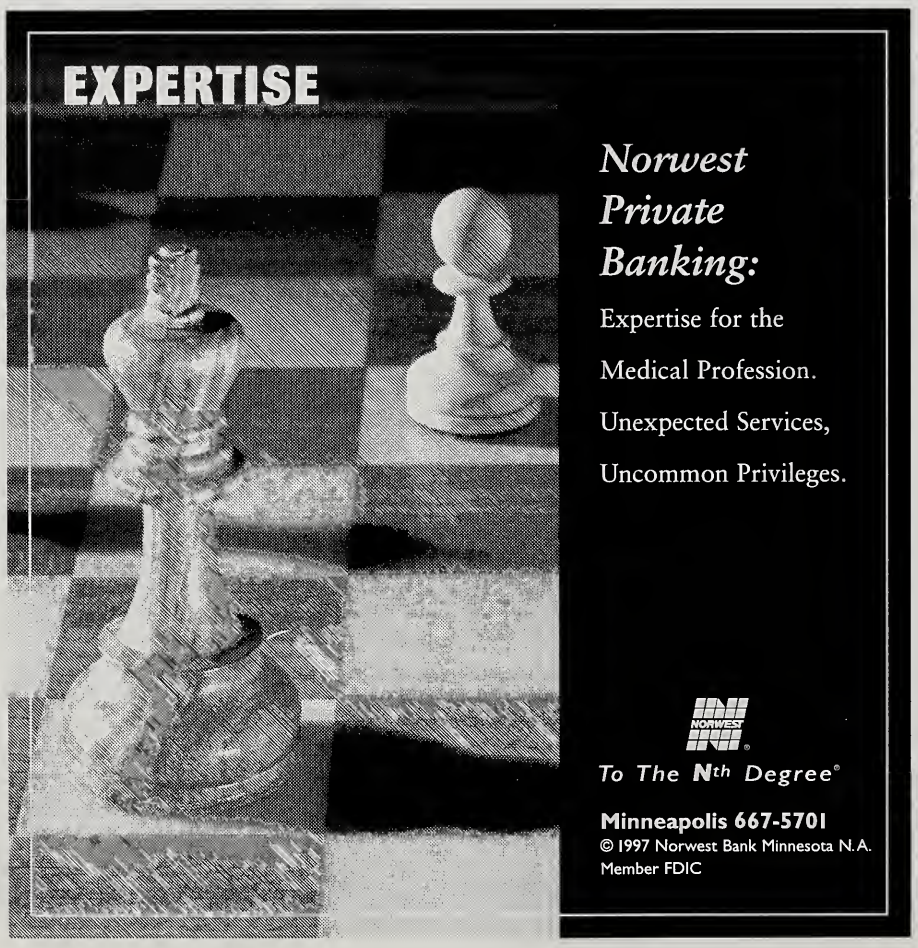
Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Occupational Health
Ob/Gyn
Pediatrics

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES



Norwest Private Banking:

Expertise for the Medical Profession.

Unexpected Services, Uncommon Privileges.

NORWEST

To The Nth Degree®

Minneapolis 667-5701
© 1997 Norwest Bank Minnesota N.A.
Member FDIC

Jalapa community embraced our tubal sterilization and vasectomy program and the patients' gratitude have convinced our small Minnesota contingent that such a project is worthwhile.

In February 1997, two similar groups visited Honduras and Nicaragua and together completed more than 100 laparoscopic tubal sterilizations. The opportunities for medical missionary projects throughout the world are legion (see the list of volunteer organizations on page 18), although finding well-planned, short-term volunteer opportunities that satisfy the needs of a specific specialty or subspecialty is more difficult. Physicians and nurses interested in volunteering with a project such as ours should contact Marc Well Nagel with Short-Term Volunteers in Mission, 612/544-6389. Health care workers fluent in Spanish are especially needed. MM

Acknowledgment

The authors wish to express their gratitude to Karla Schroeder, R.N., for her invaluable assistance attending the patients and obtaining the data and to Susan Thompson for her help compiling this manuscript. The authors also wish to express their gratitude to Drs. Stanley Greenwald, Edward Maeder, Debra Thorp, and Janet Schaeffer for their suggestions in preparing this manuscript.

John Reichert, Linda Nagel, and Norman Solberg are obstetrician/gynecologists at Park Nicollet Clinic in St. Louis Park.

REFERENCE

1. Mehta PV. Laparoscopic sterilization with the falope ring: experience with 10,100 women in rural camps. Obstet Gynecol 1981;57:345.

Announcing the opening of Bone, Muscle & Joint Inc.'s Midwest Regional Development Office

BMJI is a single specialty musculoskeletal Physician Practice Management (PPM) company.

BMJI assists with the business operations of your practice, restoring the pleasure of being a physician.

Bone, Muscle & Joint's Philosophy...

- Majority Physician Ownership
- Physician/Practice Autonomy
- Physician & BMJ Interests Fully Aligned
- Managed Regional Operating Teams
- Managed Care Network Development
- Focus On Worker's Comp



Bone, Muscle & Joint, Inc.

For more information call 1-800-414-BMJI (2654)
or in the Midwest 1-630-904-8232

General Internist

Hennepin County Medical Center, Dept. of Medicine

Hennepin County Medical Center, a University of Minnesota affiliated teaching hospital, and Hennepin Faculty Associates seek a General Internist to join the Division of General Internal Medicine as a clinician educator. Candidate should demonstrate strong clinical abilities and possess a keen interest and commitment to ambulatory care. Experience in a managed care setting is desirable. Responsibilities include providing direct patient care, educating and supervising house staff and medical students, and other duties as assigned by the Division Chief.

Depending upon experience and qualifications, the candidate would be eligible for a full-time renewable-term University academic appointment with the approval of the Department of Medicine and the Promotions and Tenure Committee of the University of Minnesota Medical School.

Hennepin County Medical Center, Hennepin Faculty Associates, and the University of Minnesota are equal opportunity educators and employers, who specifically invite and encourage applications from women and minorities.

Submit applications to: William F. Keane, M.D.
Chairman, Department of Medicine
Hennepin County Medical Center
701 Park Avenue
Minneapolis, MN 55415
Phone 612/347-6177

Last day for receipt of applications: September 1, 1997

HealthPartners®
St. Paul-Ramsey Medical Center

CME
640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

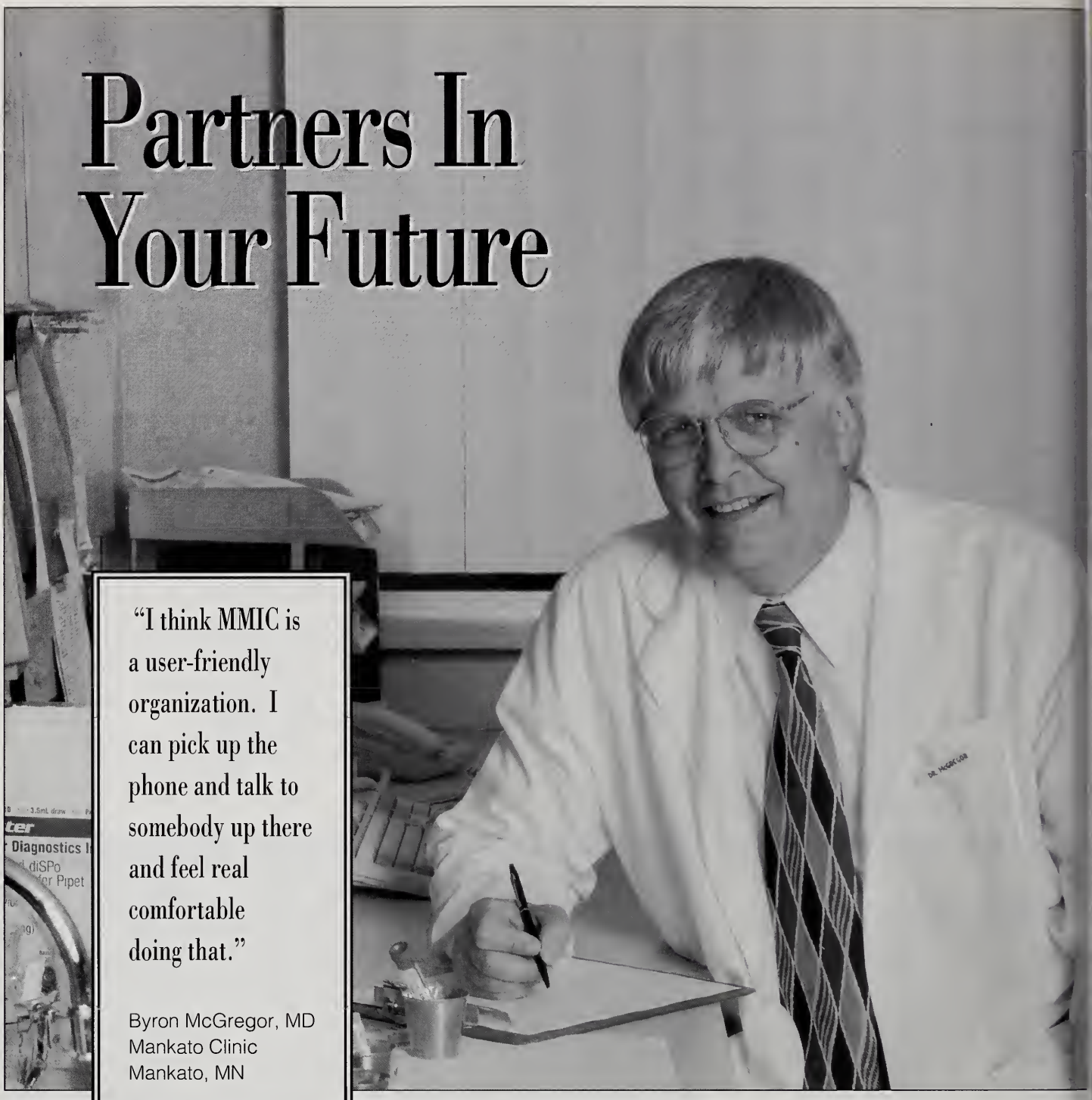
CONTINUING MEDICAL EDUCATION
1997 FALL/WINTER CONFERENCE SCHEDULE

1st Annual Env. Health Policy Institute	September 8-19
15th Annual Occ. Health & Safety Institute	September 8-19
Infectious Diseases	November 7
Workers' Compensation	November 10-11
Strategies in Primary Care	November 13-15
Changing General Surgical Practices	November 13-14
Cardiovascular Medicine	December 4-5
Pediatric Orthopaedic Update	December 5

INFORMATION AND REGISTRATION:
Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612-221-3992 • Fax 612-292-4773
St. Paul-Ramsey Medical Center/Ramsey Clinic/Ramsey Foundation are Members of the HealthPartners Family of Health Care Organizations

RAMSEY

Partners In Your Future



"I think MMIC is a user-friendly organization. I can pick up the phone and talk to somebody up there and feel real comfortable doing that."

Byron McGregor, MD
Mankato Clinic
Mankato, MN

In today's changing medical environment, physicians need to view their professional liability insurer as an important partner in their future. And what better partner can a physician have than a physician-owned and controlled liability insurer such as Midwest Medical Insurance Company. A company that understands a physician's desire to practice the art of medicine.

As your partner, MMIC is here to assist you in your new working relationships and to develop products and programs which improve patient care and lower liability exposures.

MMIC is here for the long term. We bring to the partnership a financial strength of over $251 million in assets and a total equity of over $104 million. Our rating from A.M. Best is A (EXCELLENT).

For a competitive quotation and other information on services offered by MMIC, please call us at 1-800-328-5532.

MMIC

MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S. Minneapolis, MN 55435-1891

The Monitor
News For Minnesota Physicians

Announcements

Medical Alley Presents Media Forum

National and local media representatives will address a series of health care questions at the Medical Alley forum, "What's the Story? Media Perceptions of the Healthcare Industry & Its Trends," on July 10 from 7:30 a.m. to 10 a.m. at the Ramada Plaza Hotel in Minnetonka. For more information call 612/542-3077. The Minnesota Medical Association is a member of Medical Alley, a collaborative forum that promotes an environment to enhance innovation in health care.

• • •

ROHMSID Program Seeks Funds

The St. Paul Rotary ROHMSID project must leave the old Divine Redeemer Hospital in January and is actively looking for free or rented storage space for continuing the project. In 1996, ROHMSID accumulated, sorted, boxed, and made available to mission programs approximately 1,000 boxes of reusable materials, which went to 15 countries. If you would like to provide donations to this worthy project, call Charles J. MacDonald, M.D., at 612/291-8773.

• • •

Health Fund Will Promote Primary Care

The Minnesota Department of Health, the Minneapolis Foundation, and the Robert Wood Johnson Foundation have established a new loan fund designed to promote primary care in underserved areas of the state. For more information, call Mark Schoenbaum at the Office of Rural Health and Primary Care at 612/282-3859.

Minnesota Delegation Proposes Tobacco Resolution

As *The Monitor* goes to press, the American Medical Association (AMA) is considering a resolution introduced by the Minnesota delegation at the AMA Annual Meeting that calls on the AMA to strongly oppose any out-of-court global settlement between states attorneys general and tobacco companies that does not include the following:

1. No legal immunity from product liability.
2. Full disclosure of the industry's documents and research regarding nicotine and the harmful effects of tobacco use.
3. Payments that are commensurate with past and continuing harm done by tobacco.
4. Acceptance of the Federal Food and Drug Administration (FDA) regulation of nicotine as a drug.
5. Restrictions that guarantee the tobacco industry will not market its product to children.
6. No preemption of state and local laws.
7. A tobacco-industry-funded, tobacco-use prevention and education campaign.

If the MMA resolution is adopted, it could modify the direction of current AMA policy. The AMA, along with the American Cancer Society, the American Heart Association, and the National Center for Tobacco-Free Kids, has announced support for a settlement of 40 state lawsuits and 17 class action suits against the tobacco companies. C. Everett Koop, M.D., former surgeon general and current chair of a congressional advisory board on tobacco, said he is dismayed at the statements of the four major public health organizations and believes they have undermined efforts to present a unified antismoking force.

"There is strong feeling among many delegates that the AMA Board was too hasty in announcing support for the settlement," said Paul Sanders, M.D., MMA CEO, speaking from Chicago, where the AMA meeting is in progress. "Several medical associations proposed resolutions, but the Minnesota resolution has become the focal point of discussion because it is the most thorough."

The tobacco settlement, which has been criticized by the Smoke-Free 2000 Coalition and by Minnesota Attorney General Hubert Humphrey, fails to meet several of the requirements of the AMA Minnesota delegation's resolution. The $368 billion settlement is "simply not enough to deter long-term industry behavior that damages the public's health," according to Judy Knapp, executive director of the Smoke-Free 2000 Coalition. Tobacco companies would have to pay $10 billion at the time of signing the agreement, $8.25 billion for five years, and about $15 billion a year thereafter. The settlement payments would be tax deductible.

Concerns also remain about maintaining the FDA's current authority to regulate nicotine. Under the settlement, the FDA could not ban nicotine until the year 2009 and then only if it would not create black markets in regular cigarettes. This provision suggests that "the settlement's nicotine

Tobacco continued on page 35



Viewpoint

Raymond G. Christensen, M.D.
President, Minnesota Medical Association

Minnesota Enacts Patient Protections

Thanks, in part, to the Minnesota Medical Association, Minnesota leads the nation in enacting legislation to preserve patients' trust in their physicians in a competitive marketplace.

President Clinton's advisory committee on health care quality is beginning to draft a patient bill of rights that is expected to include patient protections that Minnesota has already enacted, such as making sure physicians can freely discuss treatment options with their patients and making sure patients have basic information about their health plan.

Such measures are important in preserving quality of care and patient confidence in the health care system. The MMA nudged Minnesota toward enacting patient protections in 1995 by initiating the MMA's Quality and Coverage bill. That year the Legislature passed a number of MMA provisions related to utilization review and prohibited prior authorization requirements for emergency procedures as well as inappropriate financial incentives. The goal was to preserve the quality of health care, while allowing market forces to work.

This year, the Minnesota Legislature passed patient protection legislation that expands the protections enacted earlier. The new law protects our right to give full information to our patients by banning "gag clauses" and prohibiting health plans from retaliating against a provider for disclosing information about health plan coverage or criticizing the plan. These provisions will safeguard the patient/physician relationship, which is based on trust. Our patients need to know that we will tell them all the options regardless of whether the procedures are covered by the health plan.

Patient protections are not anti-managed care. We realize that health plans want to provide appropriate medical care, not to withhold care. But they cannot cover every possible procedure for all their enrollees. With a limited amount of money available, plans must make difficult choices and must deal with public demand for experimental procedures that may, or may not, prove effective.

Health plans may determine coverage, but ultimately patients and their physicians make the medical decisions. Patient protections make sure that people have access to the information they need to make wise decisions. We physicians have the responsibility to explain the pros and cons of the various treatment options. When patients request complementary care and out-of-plan referrals, we discuss these options as well. In doing so, we enlist our patients as partners in their care.

Our patients also have a responsibility—to be aware of the conditions of their health plans, including any restrictions on choice. The new law will make it easier for patients to know their choices by establishing a consumer assistance office to answer questions.

People who want greater choice than is available within their health plan network should be prepared to pay for it. For most patients, knowledge about health plan rules will enable them to decide whether to abide by the plan's referral system or pay a higher fee. Recently, one of my patients wanted a second opinion from a particular physician. He realized his health plan would pay only if he saw a network physician, but he was willing to pay extra to see the physician of his choice. He made the decision that was best for him.

People who have chronic medical conditions or are in an emergency situation, however, may benefit from special protections. The new Minnesota legislation requires health plans to authorize standing referrals to non-primary care specialties for enrollees who have chronic conditions. It also requires health plans to cover emergency care outside the network and outside the service area.

Clinton's panel has not decided whether it is developing legal rights or outlining appropriate consumer expectations. The question of whether to put teeth in the bill of rights will probably generate controversy. The nation might look to Minnesota's example of enacting legislation that protects the most vulnerable, guarantees disclosure of information, and lets the market operate.

Information is the key. People have the right and responsibility to know their options, plans' restrictions, and appeal opportunities. When they have the facts, patients and their physicians can be effective partners in care.

We can expect further efforts to pass patient protections at the state and national level. This session, attempts to pass "any willing provider" legislation failed, but the issue will probably resurface next year. We may also see proposals to allow lawsuits against HMOs if their denial of coverage leads to a bad outcome. The MMA will continue to be active on patient protection issues.

• • • • •

Tobacco continued from page 33

regulation provisions may be nothing more than a sham," said Knapp.

The settlement calls for a cap on the amount of legal damages tobacco companies would have to pay in a year. Damage awards would come out of an annual $5 billion tobacco company fund and there would be no more class-action lawsuits. "Immunizing the tobacco industry from punitive damages for past suffering, illness, economic harm, and death due to the use of their product is completely inconsistent with the increasingly solid legal evidence that tobacco companies have lied and deceived the public for decades about the lethal nature of their product," said Knapp.

On the plus side, the agreement calls for guidelines to control marketing and advertising, including a ban on billboards and other outdoor ads, no people or cartoons in ads or on cigarette packs, no brand-name sponsorship of sporting events or promotional merchandise, a ban on cigarette vending machines, and no product placement in movies or on television. Significantly, the tobacco companies agreed not to challenge these marketing restrictions under the First Amendment. The settlement also calls for tobacco companies to reveal documents they have kept secret and to fund a public education campaign.

Minnesota Attorney General Hubert Humphrey, who pulled Minnesota out of the tobacco settlement discussions, has concerns about the tobacco agreement and expects it to be weakened even further by the "tobacco-bankrolled Congress." The settlement must be approved by Congress if it is to take effect. Despite the settlement, the lawsuit by the state of Minnesota and Blue Cross and Blue Shield of Minnesota against the tobacco companies is expected to go to trial in January 1998. • • • • •

Human Rights Foundation of Turkey Seeks MMA Support

Mustafa Çinkiliç, a lawyer for the Human Rights Foundation of Turkey, and Douglas Johnson, executive director of The Center for Victims of Torture, met with Minnesota Medical Association staff to seek support for a resolution that the Colorado delegation is proposing to the AMA House of Delegates. The resolution asks the AMA to call on Turkey to cease all prosecution of the Human Rights Foundation of Turkey and to cease all other actions that impede its work.

This resolution comes partly in response to the conviction of a physician, Tufan Köse, M.D., for refusing to reveal to Turkish authorities the names of torture survivors who came to him for treatment at the Adana Treatment and Rehabilitation Center in Turkey. The government wanted him to reveal not only the victims' identity but also confidential information from their medical records. Although Köse was fined only $150, his conviction sets a precedent that could discourage torture victims from seeking care and could discourage physicians from treating victims, according to Çinkiliç. He says an important professional principle is at stake—confidentiality between physician and patient. "To suffer from torture may be even worse than death because the victim's ego and personality are so damaged," Çinkiliç said. "Patients believe that what they say to their physician is personal and confidential. Dr. Köse said he would never reveal this information—not even to the government. The fact that he was sentenced is proof that he kept his promise."

The Human Rights Foundation of Turkey operates four centers for the treatment and rehabilitation of torture victims in Turkey. The Foundation also monitors human rights violations in Turkey and provides data to agencies such as the U.S. Department of Human Rights. Johnson believes that Turkey's embarrassment about the publication of this data is one of the driving forces behind the government's attempt to close down the Foundation. He called a series of harassment actions against the Foundation an attempt to "kill the messenger."

Çinkiliç asked the Minnesota AMA delegation to support the Colorado resolution. "Although I am not a doctor, I believe all doctors should support this cause. Dr. Köse acted according to the principles of his profession." Çinkiliç also wants the AMA to ask the World Medical Association to support as a "universal principle" the right to physician/patient confidentiality. Çinkiliç hopes that an outpouring of concern from the world community will enable the Foundation to continue its work. • • • • •

MSS Urges Kids Not to Start Smoking



Anita Allman, a medical student at the University of Minnesota, and the AMA Extinguisher at a booth sponsored by the MMA Medical Student Section and WCCO-Radio at the Mall of America in May.

Geographic Coalition Supports 50/50 Blend of Rates

The Minnesota Medical Association spearheaded a Geographic Coalition letter-writing campaign to all U.S. senators and representatives, urging them to support proposals in Medicare reconciliation legislation that would begin to correct the wide variation in payment rates to Medicare managed care organizations.

The Geographic Coalition urged support for the 50/50 blend of national and local managed care rates proposed by the House Ways and Means Committee. This proposal would phase in payment rates based on 50 percent of the national average rate and 50 percent of the local rate. Phased in over five years, the 50/50 blend would gradually reduce the wide variation in county rates and increase stability. The change would also ensure that medical practice styles, utilization rates, and access to care would not inappropriately affect payment rates.

In addition, the coalition urged Congress to establish a minimum managed care payment floor.

Although the main focus of the letter was on managed care rates, the coalition also encouraged Congress to require the Health Care Financing Administration to review the appropriateness of fee-for-service payment areas and determine whether there is a need to combine or divide payment areas because of demographic or economic changes.

Visit the Geographic Coalition website at www.mnmed.org/gc

• • • • •

Legislative Summary	*Position*	*Outcome*
MinnesotaCare bill to reduce the 2 percent tax, repeal the $400 surcharge, and expand MinnesotaCare eligibility.	Support	Signed
Bill to repeal the growth limits for health care providers.	Support	Signed
Patient Protection bill to reinstate ban on exclusive contracts, prohibit gag clauses, prevent health plans from retaliating against providers for disclosing information about coverage, etc.	Support	Signed
Minnesota Department of Health bill to create a statewide immunization registry.	Support	Failed
Mothers against Drunk Drivers bill to reduce the blood alcohol level needed to trigger DWI offenses for minors.	Support	Vetoed
Bill to require health plan companies to allow women direct access to obstetricians and gynecologists within the plan network without referral or prior approval.	Support	Signed
Tobacco licensing bill to license all retail outlets that sell tobacco, set fines for employees who sell to anyone under age 18, require compliance checks, ban self-service displays of single cigarette packs, and require tobacco companies to report traces of five toxins.	Support	Signed
Bill to ban tobacco billboard ads.	Support	Failed
Bill to make failure to wear a seat belt a primary offense.	Support	Stalled
Child safety belt bill to allow drivers to be ticketed if children between the ages of 3 and 15 are not wearing seat belts.	Support	Failed
Bill to limit the use of "physician" to medical doctors and doctors of osteopathy.	Support	Stalled
Bill to require Minnesota schools to start no earlier than 8 a.m.	Support	Failed
Right to Carry Firearms bill to change existing law giving local police officials the authority to decide whether to issue permits to carry concealed weapons.	Oppose	Stalled

Schools Finally Heed MMA Advice on Teen Sleep Needs

Thanks in part to MMA efforts to awaken the public about the sleep needs of teenagers, the Minneapolis School Board approved in May a major schedule change. The groundbreaking shift to later school start times was adopted almost unanimously shortly after a bill that would have required later start times failed in the Legislature. As a result of the school board change, high school students will start at 8:40 a.m. rather than at 7:15 a.m. and middle school children will start at 9:40 a.m.

Mark Mahowald, M.D., a neurologist at Hennepin County Medical Center, said he is "pleased and delighted" by the board's recent decision. "This is a good example of how knowledge gained through basic science and clinical research can affect sound public policy," Mahowald said.

The MMA began advocating the elimination of early school starting hours in 1993 in response to a resolution passed by the MMA House of Delegates. In a letter to school board superintendents, the MMA pointed to scientific studies showing adolescents' biological need to sleep longer and later than younger children. Studies show that most adolescents need more than nine and a half hours of sleep. Research also indicates that teenagers' sleep cycles are different from young children's, causing them to stay alert later at night and to require more sleep in the morning. The findings were good news to many teenagers, vindicated by medical evidence that it is not necessarily laziness, but biology that makes the snooze button so irresistible at 6:30 a.m.

Despite widespread interest in the MMA's advice, Edina was the only school that had shifted to a later start time by the fall of 1996. Frustrated by other schools' slowness to change policy, the Children's Defense Fund proposed legislation that would have required all state high schools to start after 8 a.m. Many legislators, including St. Paul DFLers Rep. Matt Entenza and Sen. Sandra Pappas, supported this legislation in hopes that it would help decrease juvenile crime, most of which occurs in the afternoon when students are out of school and unsupervised. Faced with strong opposition from the Minnesota School Board Association, the bill failed, but voluntary change quickly followed.

Mahowald applauded the MMA's role in the policy breakthrough. "Change can happen when you have good scientific data and people who are committed to educating the public," Mahowald said. • • • • •

Dr. Mulder Signs Daycare Proposal



Minnesota Representative Richard Mulder, M.D., R-Ivanhoe, signs an omnibus bill that includes his proposal to subsidize parents who stay home with their babies.

Minnesota Medical Association member Rep. Richard Mulder, M.D., proposed an amendment during the 1997 session that allows working parents who are eligible for state daycare subsidies to leave their jobs for up to one year and use their child care subsidies to help make up the lost income. Mulder says this would save the state money because each family would be paid only 75 percent of the cost of paying a daycare provider. Currently, a two-parent family with one child and a $25,000 annual income is eligible for a monthly child care benefit of $281. Under Mulder's provision, one parent may choose instead to stay home and receive 75 percent of that benefit, or $211 a month for up to 12 months.

The impetus for Mulder's proposal came from a number of studies on the impact of early childhood experiences on attachment with parents, social behavior, and intelligence. • • • • •

Legislative Report Is Available

The 1997 Legislative Report will be available soon. If you would like to receive a copy, call Pat Biersach at 612/378-1875 or 800/DIAL-MMA (342-5662). • • • • •

MMA Flood Relief Fund

Help Restore Access to Health Care in Ada

Bridges Medical Center in Ada, Minnesota, was severely damaged by the floods.

Money is needed to rebuild this city-owned health care facility, which is located in a health professional shortage area.

The Minnesota Medical Association has set up a special fund to benefit the Bridges Medical Center, which includes a hospital, nursing home, and clinic. One hundred percent of the contributions from Minnesota's physician community will go directly to restoring health care services to people in this medically underserved area.

"I pray no major trauma will happen. Now we realize how terrible it is to be without a hospital and clinic. So far no one has had a heart attack, but something's bound to happen."

—Kyle Rasmussen, clinic manager

The MMA Flood Relief Fund has been established through the Minnesota Physicians Foundation, a charitable foundation established by and affiliated with the Minnesota Medical Association.

All contributions are tax deductible. Please make checks payable to the Minnesota Physicians Foundation and write "Flood Relief Fund" on the memo line. Send your contribution to 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, Attn: Kimberly Halva.

Name _____

Address _____

MPF also accepts VISA, MasterCard, and Discover.

Card Type _____

Issued to _____

Card # _____

Signature _____ Exp. Date _____

MMA Forum Addresses Goals of Medicine and Public Health

Philip Lee, M.D., former assistant health secretary for the U.S. Department of Human Services, called for a closer link between medicine and public health at the June 13 conference on the goals and relationship of medicine and public health in Minnesota, sponsored by the Minnesota Medical Association, the Public Health Association, and the Center for Population Health.

In the early part of the 20th century, 90 percent of the improvements in the health of the population could be traced to public health measures rather than to personal medical care, according to Lee, but in recent years, technological advances have r ed in a "Golden Age of Medic which relies more on curing tha preventing disease.

"The dawn of the sanitary revolution had spectacular results," Lee said. The combination of improved sanitation, immunization, quarantine, better socioeconomic conditions, better nutrition, and fewer, more widely spaced children dramatically reduced infections, especially among the poor.

After the development of antibiotics and high-tech medicine, however, there were fewer incentives for public health measures. People worry less about prevention if there is a cure. Recently, a city's contaminated water supply caused 400,000 cases of diarrhea, but the outbreak wasn't discovered until local pharmacies ran out of the appropriate medication. Once the cause was known, the contamination was corrected in days.

Reduced vigilance can lead to serious public health problems. With society's guard lowered against tuberculosis, drug-resistant TB developed. Lee called antibiotic-resistant infections "a bomb that is about to go off." He also warned about backsliding on public health measures such as keeping harmful additives out of gasoline. Because of laws against lead in gasoline, there has been less lead poisoning for the past 75 years. But recently the Environmental Protection Agency tried and failed to prevent companies from adding manganese to gasoline. Although there are some indications manganese could cause violence, no testing was required.

Lee called for a combination of medical and public health approaches, which he says has proven especially effective in reducing hypertension that leads to cardiovascular deaths and in shifting attitudes toward tobacco use. Lee suggested the following measures:

- better performance measures and information systems;
- incentives for collaboration;
- policies to protect the public good, such as care for the uninsured, public health education, and research into social behavior; and
- links with communities to prevent problems such as violence and alcohol abuse.

See the August issue of *Minnesota Medicine* for more information about this public health forum. • • • • •

MMA PSA Addresses Violence



MMA President Raymond G. Christensen, M.D., and actor John Davidson, who sang the national anthem, at Stop the Violence Day at the Dome.

Watch for the MMA television public service announcement starring John Davidson, who recently appeared as Theodore Roosevelt in the Ordway production of "Bully." Davidson generously offered his time and talent to urge people to talk to their doctor about family violence. Paragon Cable, a frequent partner with the MMA in antiviolence activities, donated production, editing, and videotape dubbing services. The Ordway Theater donated the use of its stage and crew to produce the PSA, which will appear on 26 Paragon cable stations in the Twin Cities area, as well as on KSTP and WCCO in the Twin Cities and on KDLH in Duluth.

"We are grateful to Paragon and to the Ordway as well as to John Davidson for their collaboration in bringing an important message to the public," said Raymond G. Christensen, M.D., president of the MMA. "Physicians can help people find a way out of family violence." • • • • •

MMA ANNUAL MEETING

September 14-16, 1997
Madden's Resort, Brainerd

Sunday, September 14

12:00 noon – 6:00 p.m.
General Registration

12:00 noon – 2:00 p.m.
MEDPAC Annual Meeting

2:00 p.m. – 4:00 p.m.
Board of Trustees Meeting

2:00 p.m. – 3:00 p.m.
Young Physician Section

3:00 p.m. – 4:00 p.m.
Resident Physician Section

4:00 p.m. – 6:00 p.m.
1997 Issues Forum

6:00 p.m. – 8:30 p.m.
Welcome Reception,
Outdoor Barbecue

8:00 p.m. – 9:00 p.m.
Women Physician Reception

Monday, September 15

6:00 a.m. – 7:30 a.m.
Breakfast

6:45 a.m. – 5:00 p.m.
General Registration

7:00 a.m. – 8:00 a.m.
Medical Student Section

7:00 a.m. – 8:45 a.m.
Component Society Caucuses:
Ramsey
Hennepin
Greater Minnesota

9:00 a.m. – 10:30 a.m.
House of Delegates (Session I)

10:30 a.m. – 11:15 a.m.
AMA Open Forum

11:15 a.m. – 12:45 p.m.
Awards Lunch

1:00 p.m. – 3:30 p.m.
Reference Committee
Open Hearings

3:30 p.m.
Shot Gun Golf Tournament

3:30 p.m. – until completion
Reference Committee
Executive Session

4:30 p.m. – 6:00 p.m.
Organized Medical Staff Section

5:00 p.m. – 6:00 p.m.
AMA Delegation Meeting

6:30 p.m. – 7:00 p.m.
Preinaugural Reception

7:00 p.m. – 9:00 p.m.
President's Inaugural Dinner
and Festivities

9:00 p.m.
Afterglow Reception

Tuesday, September 16

7:00 a.m. – 8:30 a.m.
Breakfast

7:00 a.m. – 8:00 a.m.
Board of Trustees
Breakfast Meeting

8:30 a.m. – 12:00 noon
General Registration

8:30 a.m. – 10:15 a.m.
Component Society Caucuses:
Ramsey and Hennepin
Greater Minnesota

10:30 a.m. – 3:00 p.m.
(Includes lunch)
House of Delegates (Session II)

12:00 noon
Spouse Luncheon

3:00 p.m.
Board of Trustees
Organizational Meeting

The Monitor
JULY 1997

PRESIDENT
Raymond G. Christensen, M.D.

CHAIR, BOARD OF TRUSTEES
Timothy J. Crimmins, M.D.

CHIEF EXECUTIVE OFFICER
Paul S. Sanders, M.D.

EDITOR
Lorrie Holmgren

OFFICE PRODUCTS AT PRICES THAT WILL MAKE YOU *gasp*

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED



We all need office supplies. The key is to find the vendor that carries everything you need at the best possible prices. MMBR has selected Office Depot as our endorsed office supply vendor. Through MMBR, you can save an average of *40 percent off* all general office supplies and furniture. MMBR has also arranged retail store pricing on *electronics, business machines, and software,* a special *Purchasing Card* to take advantage of volume discounts at 7 Twin Cities retail stores, and additional *frequent buyer discounts.* Ask about our *convenient billing options.* MMBR can put the immediate response of *Internet* and specialized software ordering at your fingertips, and *next day delivery* is standard with nearly all products. For personal attention and unparalleled service, call 623-2860, or toll free 800-298-MMBR (6627), and ask for our office supply program.

MMBR

OFFICE SUPPLY

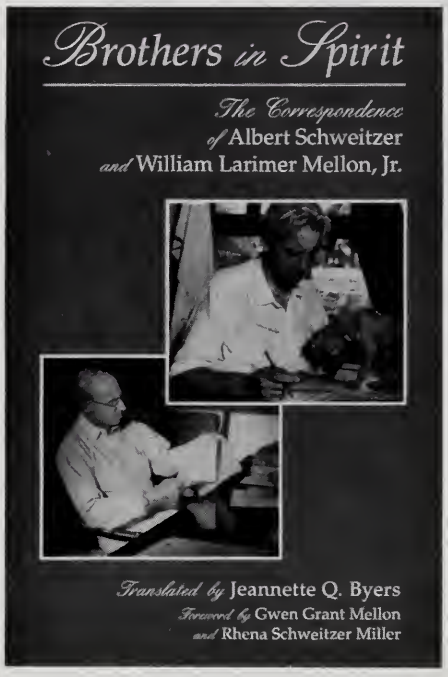
MINNESOTA MEDICAL BUSINESS RESOURCES
OWNED BY MMA & HMS

A Tale of Two Missionaries

"Brothers in Spirit: The Correspondence of Albert Schweitzer and William Larimer Mellon, Jr." tells the stories of two men in pursuit of a common dream.

Reviewed by Charles R. Meyer, M.D.

Letters reveal telling tales about their writers. Correspondence tells two tales. Little by little, a portrait of the correspondents unfolds with a natural poignancy not seen in simple biography. "Brothers in Spirit: The Correspondence of Albert Schweitzer and William Larimer Mellon, Jr." (Syracuse University Press, 1996), translated from French by Jeannette Q. Byers, is a saga of friendship, mission, and dedication. It is also the story of an unusual and moving mentorship.



William Larimer Mellon was the son of the founder of Gulf Oil Corporation. His first 37 years followed a script in genteel breeding—prep schools, a brief enrollment at Princeton, marriage, three children, a successful cattle ranch in Arizona. Then in 1947, a life-altering epiphany came in the unlikely form of a brief article in *Life* magazine that described Albert Schweitzer's work at his clinic in Gabon, West Africa. After reading the article, Mellon wrote a letter to Schweitzer that begins "Brothers in Spirit" and goes on to describe Mellon's desire to go to medical school and devote his remaining life to medical mission.

Despite discouragement from many medical schools and warnings from Schweitzer about the hard road, Mellon did finish his formal education over the next seven years at Tulane University in Louisiana. By the time he graduated from medical school in 1954, Mellon had chosen Haiti as the site for his medical work. He constructed a hospital in the Artibonite River Valley and named it after his mentor. Mellon took his whole family there and labored at this mission for the rest of his life. The Hospital Albert Schweitzer is still in operation today.

The letters Mellon and Schweitzer exchanged are both moving and mundane. Mellon praises Schweitzer as "the ideal of a pure soul." Perhaps most eloquent is Mellon's initial missive in which he asks Schweitzer where he should direct his energies to "lighten the burden of the sons of Adam," quoting the 17th chapter of the Gospel of Mark in which Jesus calls on his followers to "go thy way, sell whatsoever thou hast, and give it to the poor, and thou shalt have treasure in heaven." Few people have taken a Bible verse so literally.

Such soaring ideals mix with drab details. Schweitzer's letters contain practical, sometimes paternal, advice about medical school: "Don't waste time on specialized subjects like tropical diseases"; and advice about running a hospital: "You must be the absolute master of your establishment." In response, Mellon lists plans for supplying his hospital with equipment and doctors. At times, Mellon and Schweitzer sound like contractors planning a construction project.

Most of Schweitzer's letters describe the toils of missionary work. Trouble recruiting capable physicians is a recurring theme. Schweitzer was 72 when this correspondence started, and he mentions his physical fatigue in letter after letter.

Mellon's journey to becoming a medical missionary is not unlike that of Schweitzer, who said he felt justified in devoting his life to scholarship and the arts until age 30. "But after that I [shall] devote myself directly to serving humanity," declared Schweitzer at age 21. True to his word, he left a world-class career as theologian, musician, and music scholar to enter medical school. In 1913, at the age of 38, he headed to Gabon to start his missionary life.

"Brothers in Spirit" tracks parallel souls journeying similar paths 40 years apart. Both men left comfort-

able, established careers and veered off into the unknown to pursue a dream. With only three personal meetings between Schweitzer and Mellon, their letters are what build a spiritual bond over the 18-year relationship.

What emerges most clearly from these pages is the character traits of the two correspondents: quiet resolve, relentless drive, unquestioning faith. "Brothers in Spirit" is a portrait of dreams pursued by these two men, both of whom followed Schweitzer's advice: "Grow into your ideals, so that life can never rob you of them." MM

Charles Meyer is editor-in-chief of Minnesota Medicine *and an internist with Consultants–Internal Medicine in Minneapolis.*

HUDSON PHYSICIANS

FAMILY PRACTICE

Hudson Physicians, a fast-growing primary care clinic located in Hudson, Wisconsin, nestled in the scenic St. Croix River Valley, is seeking physicians to join our group of 12 .

Located 15 minutes from St. Paul, Minnesota, Hudson Physicians offers the best of both metropolitan access and outreach/rural family qualities that enhance both practice and lifestyle.

Excellent salary guarantees, benefits and opportunities.

Please contact:
Steven L. Muellerleile, Administrator
Hudson Physicians, Inc.
402 Wisconsin St.
Hudson, WI 54016

HUDSON PHYSICIANS
A division of Western Wisconsin Medicol Associotes S. C.

Weigh The Facts!

Benefits to clinics, hospitals and practitioners include:
-Large pool of seasoned physicians.
-Integral part of medical referral network.
-Current in medical care policies, procedures and protocol.

To physicians of all specialties:
-Confidentiality prioritized.
-Financial incentives.
-Medical malpractice.
-Personalized service tailored to your needs.



Whitesell
Medical Locums, Ltd.

Eight First Avenue South
Buffalo, MN 55313
1(800) 876-7171
1(800) 295-6373
***Local* 682-5218 or 682-5906**
FAX (612) 682-4791

CENTEON
Bio-Services, Inc.

Centeon Bio-Services, a leader in the collection of plasma proteins, is seeking a part-time physician to give physicals to our blood plasma donors. If you are looking for a low-key, non-stressful environment, please call and ask for Guy Stinson, center manager.

Centeon Bio-Services
1054 University Ave.
St. Paul, MN 55104
612-646-2556

Creative solutions for all your health care legal problems

MEMBERS OF THE FIRM'S HEALTH LAW GROUP:
Daniel J. McInerney, Jr. 335-1782
David R. Melloh 335-1674
Timothy A. Johnson 335-1789

LAW OFFICES
150 SOUTH FIFTH STREET SUITE 2300
MINNEAPOLIS, MINNESOTA 55402
612-335-1500

LEONARD STREET AND DEINARD

People and Places Making Medical News

People

Educator and Researcher of the Year Awards

The Institute for Research and Education HealthSystem Minnesota has named Park Nicollet Clinic cardiologist **George S. Strauss, M.D.**, Educator of the Year. The annual award recognizes individuals whose education objectives are measurable and consistent with the mission of the institute, affect positive changes in health outcomes, are scientifically sound, and are based upon current and reliable sources. Preference is given to candidates whose primary responsibility is not education and who have a long-term involvement in education.

The institute has also named Park Nicollet allergist **David F. Graft, M.D.**, Researcher of the Year. This annual award recognizes individuals whose research is original, applicable to clinical practice, and published in peer-reviewed journals. Preference is give to individuals whose primary responsibility is not research.

PIAA's Award of Excellence

Minneapolis physician **George Tangen, M.D.**, received the 1997 Peter Sweetland Award of Excellence by the Physician Insurers Association of America (PIAA). The annual award recognizes an association member embodying high ideals and ethical standards.

Tangen, a former president of the Hennepin County Medical Society and trustee of the Minnesota Medical Association, was a member of Midwest Medical Insurance Company's board for 11 years—seven as MMIC's president. He's also been a leader of the PIAA, an association owned by 60 doctors and dentists that provides professional medical liability insurance.

HealthPartners Institute for Medical Education Board

HealthPartners Institute for Medical Education, which provides structure for all medical education programs administered through HealthPartners and St. Paul-Ramsey Medical Center, has appointed the following individuals to its board of directors: **Macaran Baird, M.D.; Nancy Baker, M.D.; Mary Brainerd, M.B.A.; Mary Broderick, Ph.D.; Robert Garland, M.B.A.; Anjali Goel, M.D.; Virginia Gray, Ph.D.; Goerge Isham, M.D.; Allan Kind, M.D.; William Litchy, M.D.; John Marini, M.D.; Alfred F. Michael, M.D.; Steve Mosow, M.P.H.; Gordon Mosser, M.D.; Brian Rank, M.D.; and John Weigelt, M.D.**

Allina Board of Directors

The Allina Health System board of directors has reappointed **Terril H. Hart, M.D.**, and **William W. George** board chair and vice chair, respectively. Hart is co-founder of Wayzata Children's Clinic, where he is a pediatrician, and George is president and chief executive officer of Medtronic, Inc.

Also appointed to the board were **Lowell L. Becker, M.D., Kenneth D. Holmen, M.D., David A. Rothenberger, M.D., and Judith Shank, M.D.**

Places

St. Paul-Ramsey Medical Center to Change Its Name

St. Paul-Ramsey Medical Center will become Regions Hospital later this summer—a name change intended to erase the medical center's image as a county-owned hospital serving mainly city and county residents.

The new name will better reflect the broad services the hospital offers and the diverse patient population it serves, said hospital spokesperson Pat **Motherway** in a *St. Paul Pioneer Press* article.

Several factors influenced the name change: St. Paul and Ramsey County health departments are merging into a single system that will be called the St. Paul-Ramsey County Public Health Department. "We think there's an opportunity for added confusion," said **Mary Brainerd**, executive vice president at HealthPartners.

Also, hospital officials believe a number of their programs, including their highly regarded trauma and burn treatment centers, attract patients from a broad area. "The name is designed to help communicate that it's a regional asset and a regional hospital," said Brainerd.

For its first 114 years, the hospital was owned by Ramsey County. In 1986, the Minnesota Legislature passed a bill that turned over ownership to a nonprofit corporation, Ramsey HealthCare Inc. HealthPartners and the hospital merged in 1993.

Immunization Action Coalition Receives Award

The St. Paul-based Immunization Action Coalition, publisher of *Needle Tips & the Hepatitis B Coalition News*, has received the 1997 Centers for Disease Control and Prevention annual Partners in Public Health Award.

Family physician **Deborah Wexler, M.D.**, founder and executive director of the coalition, accepted the award, which recognizes the coalition's efforts in achieving high levels of routine infant hepatitis B immunization.

PA Program Granted Accreditation

The physician assistant program sponsored by the University of Wisconsin–La Crosse, Gundersen Medical Foundation, and the Mayo School of Health Related Sciences has been granted initial three-year

accreditation by the Commission on Accreditation of Allied Health Education Programs.

Accreditation demonstrates the program's compliance with national physician assistant education standards and allows program graduates to take the national board exam. Completion of the exam is required to enter clinical practice.

The program's mission is to educate primary care physician assistants with an emphasis on practice in rural and underserved areas of the region.

"We're excited to work closely with both the University of Wisconsin–La Crosse and Gundersen Lutheran on a program that will bring more health care providers into rural, underserved areas of our region," said **Kevin Fleming, M.D.**, a Mayo Clinic internal medicine specialist and co-medical director of the program.

Mayo MedAir Adds to Its Service

Mayo Clinic has purchased a new King Air B-200 air ambulance for its Mayo MedAir Service. The aircraft will be used exclusively by patients requiring medical care while traveling to and from Mayo or other medical centers.

The new fixed-wing long-distance aircraft, which will be used within a 500-mile radius of Rochester, is equipped to care for patients of any age who are critically ill or injured and in relatively stable condition. The equipment on board matches medical and diagnostic equipment available in the Emergency Trauma Center at Saint Marys Hospital–Rochester. It includes built-in patient-care systems, monitoring devices, a computer network, and digital communication links, and it allows the flight team to exchange voice and digital data with physicians and allied health staff at the Emergency Trauma Center.

Mayo MedAir is certified by the Commission on the Accreditation of Medical Transport Services, which evaluates medical air services for safety and quality.

Park Nicollet Clinic Expands

Park Nicollet Clinic HealthSystem Minnesota is adding 48,000 square feet to its St. Louis Park facility by building two more floors onto the existing two-story building that houses primary care and medical services, such as family practice, internal medicine, and urgent care departments.

Construction began in mid-April. Phase one, construction of the third and fourth floors, is expected to take six to eight months. Phase two, completing the internal space, will take another four to six months. Construction is not expected to interfere with patient or visitor access to the building. The addition should be ready for occupancy next February.

WestHealth Breaks Ground on $10 Million Expansion

WestHealth in Plymouth began breaking ground on its $10 million expansion, which will add 80,000 square feet to the existing 120,000 square-foot ambulatory care facility. The expansion is in response to a growing demand for outpatient services in the west-metro area.

WestHealth is one of the first health care organizations in Minnesota to offer a number of ambulatory services at one location. When the new facility is completed next spring, 20 clinics will be added to the center, including a dental care center, additional physician clinics, physical therapy, and the Gillette Children's Specialty Healthcare clinic.

HealthEast St. John's Begins Renovation, Expansion

HealthEast St. John's Hospital began construction on its three-phase expansion June 16. Phase one, reorganizing the land and roads in anticipation of future buildings and expanding the existing parking capacity, is expected to be completed by December 1997.

Phase two involves the design and construction of a medical specialty center (an additional medical office building) and an ambulatory care center. Phase three will include renovating and expanding the existing hospital space, to be completed by the end of calendar year 1999. Construction plans include expanded cardiac rehabilitation, radiology, pharmacy, surgical services, and laboratory departments, and a relocated and expanded emergency room and education center.

Mall of America Women's Clinic Opens

A medical clinic devoted exclusively to breast and cervical cancer screening for women is now open at the Mall of America. Sponsored by the city of Bloomington and the Minnesota Department of Health, the clinic offers a wide range of services, including clinical breast exams, mammograms, Pap smears, pelvic exams, and information on breast self-exams.

The clinic, which opened June 1, is located on the first level near the mall's west entrance, adjacent to the Quello Clinic. The new clinic offers extended hours Mondays, Thursdays, and Saturdays. Special screening days are set aside for certain cultural, neighborhood, and work-site groups and others with special needs or interests.

Screening services are free to Minnesota women 40 years of age and older who either do not have health insurance or have coverage that does not pay the entire cost of tests. Women who have health insurance or who want to pay for screening services also are encouraged to visit the clinic.

The city runs the clinic, and the state subsidizes the free screening under a grant from the Centers for Disease Control and Prevention.

Home for Hispanic AIDS Patients Opening in Minneapolis

A home for AIDS patients that emphasizes Latino cultures will open this fall or early next year at 31st Street and Harriet Avenue South in Minneapolis. AGAPE, which already has one Minneapolis home for AIDS patients, is building the home to accommodate the

growing numbers of Hispanic AIDS patients. The home, AGAPE Dos, will not exclude anyone, but it will have a Hispanic atmosphere.

The number of reported AIDS cases among Latinos, blacks, and other people of color in the Twin Cities has grown steadily over the years. In Minnesota, 1.6 percent of the population identified themselves as Hispanic in 1994, while 4 percent of the state's AIDS patients are Hispanic. While blacks accounted for only 2.7 percent of the state's 1994 population, 33 percent of new AIDS patients from April 1996 to March 1997 were black.

The Perfect Fit...

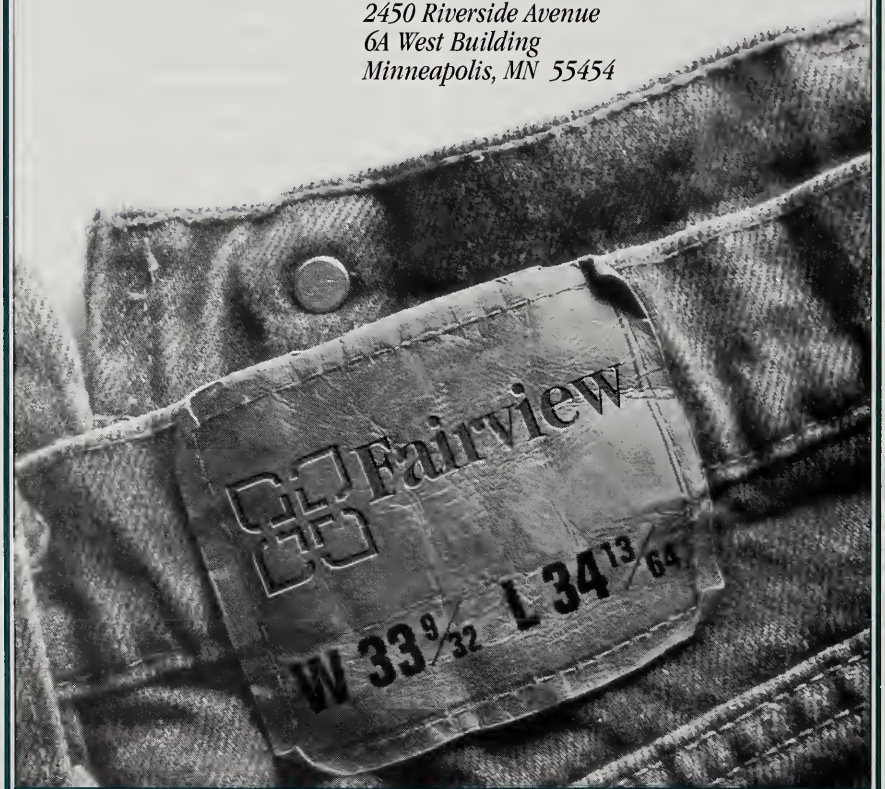
...is a rare find. Fairview Health System represents a wide spectrum of practice and lifestyle options in Minnesota. We will help you locate opportunities that are tailored to fit your needs in communities that match your size.

Opportunities now available in communities large, medium and small (and sizes in between) for...

- **Endocrinology**
- **Family Practice**
- **General Surgery**
- **Internal Medicine**
- **Obstetrics/Gynecology**
- **Orthopedic Surgery**
- **Urgent Care**
- **Urology**

Fairview

Physician Recruitment & Retention Dept.
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454



612-672-2288 or 1-800-842-6469 • E-mail: fhsrecruit@aol.com

Socioeconomics

UCare Funds New Programs

UCare Minnesota plans to work with nine counties in metropolitan and central Minnesota to fund community-based health care programs developed by county public health agencies. It will invest $300,000 in the projects.

"We have seen that by working with counties and social service agencies, we can develop many innovative programs and services that benefit both our members and their communities," said **Nancy Feldman**, UCare chief executive.

UCare is also aiding a metro-wide effort initiated by the Center for Population Health to establish an immunization registry. UCare's funding will cover first-year costs, including the cost of hiring staff to initiate the project.

Law & Policy

Humphrey Refuses to Settle in Tobacco Lawsuit

While several state attorneys general and private attorneys discuss possible lawsuit settlements with the tobacco industry, Minnesota **Attorney General Hubert Humphrey III** stands strong in his decision to meet the industry in court. Humphrey's three-year-old lawsuit goes to trial in January.

In a speech before the American Lung Association in late May, Humphrey questioned the advisability of settling with the tobacco industry, warning that it could be a "false solution that guarantees the merchants of death another 25 years of uninterrupted prosperity."

Innovations

Minnesota Teen First in World to Use Insulin Pump Modem

A Minnesota teenager has become the first person in the world to use

a new insulin pump modem, the Disetronic D-Modem, for management of her diabetes. The modem is the first transtelephonic communication device developed to transmit insulin pump data from patients' homes to their doctors' offices, allowing people with diabetes to use an insulin pump without traveling to a medical center for device programming.

The teenager, **May Jarilyn Whitefeather**, 17, lives on the Red Lake Indian Reservation 35 miles north of Bemidji, Minnesota. She was diagnosed with diabetes six years ago. When she became pregnant, her blood sugars became increasingly difficult to manage. Despite an insulin dosage of 280 units per day, her blood sugars remained high and posed a risk to her unborn son. Whitefeather's physician referred her to **Mehmood Khan, M.D.**, director of the Hennepin Diabetes Center and head of the Division of Endocrinology, Diabetes and Nutrition at Hennepin County Medical Center in Minneapolis.

Khan suggested an insulin pump, but without the new modem, it would have been nearly impossible for Whitefeather to safely use the pump given the 300-mile distance between her home and the nearest pump management location in the Twin Cities. With the modem, data from her pump can be downloaded directly to a computer in Minneapolis, and the health care team can then change the pump settings using the telephone lines. Whitefeather's blood sugars have improved greatly, and her pregnancy is progressing well.

Medical Research

Preventive Mastectomies Reduce Breast Cancer Risk

Women with a strong family history of breast cancer who have both breasts removed significantly reduce their risk of getting breast cancer, according to a Mayo Clinic study presented at a recent meeting of the American Association for Cancer Research.

Lynn Hartmann, M.D., and colleagues identified 2,475 women who had had preventive mastectomies. Of the women, 950 had both breasts removed, and 1,525 had one breast removed after cancer in the other breast. Of the 950, seven developed breast cancer over a period of 17 years. Using a statistical model, the researchers estimated that these women would have developed 76 breast cancers without the surgery. Of the 1,525 women who had one breast removed, nine breast cancers have been documented so far.

Women in Their 40s Benefit from Mammograms

Women in their 40s are more likely to beat breast cancer if it is detected by mammography rather than by some other means, according to research conducted by the Oncology Research Department at HealthSystem Minnesota and published in the May 15 issue of *Cancer*.

The study compares breast cancer outcomes of 971 women in their 40s according to methods of detection. After eight years, women with mammographically detected breast cancers had a survival rate of 87.5 percent, which was significantly better than the 70 percent to 75 percent survival rates among women whose tumors were detected by breast self-exam, clinical breast exam, or patient incidental finding. Breast tumors detected by mammography were significantly smaller and more likely to be localized than tumors detected by other means.

The study, funded by a grant from the Foundation HealthSystem Minnesota, used data from The Upper Midwest Oncology Registry Services and involved women diagnosed with invasive breast cancer between 1986 and 1992.

Prostate Cancer Survivors Report Difficulties Long After Treatment

Many men undergoing treatment for clinically localized prostate cancer continue to experience urinary, bowel, and sexual dysfunction long after treatment,

First Call Physicians, Inc.
A Locum Tenens Service
500 Eighth Ave. S.
Buffalo, MN 55313

Clinics/Hospital | **Physicians**

Locums Coverage
=
Revenue

- Patients falling through the gaps?
- Physician burn-out or illness?
- Shortage of physicians?

- Earn more with less time.
- No administrative headaches.
- Malpractice premium paid.

Experience, Service, Honesty
Call (metro) 682-3852
(toll free) 888-682-3852

(You'll be glad you did!)



"The climate is ideal - lots of sunshine and no humidity." *Milton Brinton, M.D.*

GASTROENTEROLOGIST

WASHINGTON - A unique opportunity now exists for a well-trained GI who has skills in therapeutic endoscopy. This new practice at our 19 provider multispecialty clinic in Moses Lake, Washington, has been developed as an outreach program from our central 140 physician group clinic in Wenatchee. Demand for services has reached the point to warrant a fulltime resident gastroenterologist.

The position entails full time GI and sharing endoscopy call with a general surgeon in this lake front community. The clinic has a recently completed ambulatory surgery and endoscopy center with video endoscopy. Samaritan Hospital, a 50 bed acute care hospital with well equipped ICU and endoscopy units, as well as a 24-hour staffed emergency department, is located less than a mile away.

Moses Lake, on the shores of a large recreational lake of the same name, is located in central Washington. The community, recently ranked among the top 100 smaller communities in the U.S., has a population of 15,000 with 60,000 in close proximity. The prospect for growth is excellent in part due to a desirable location with one of the largest airports in the state (site of a major airline pilot training facility) and convenient interstate highway access.

Abundant recreational opportunities exist on and around the lake as well as alpine skiing 65 miles away.

Please send CV to James Brown, M.D. -
P.O. Box 489
Wenatchee, WA 98807
FAX (509) 664-7178
see our home page @ http://www.wvc.com

Wenatchee Valley Clinic

Family Practice Residency Faculty

La Crosse-Mayo (formerly St. Francis-Mayo) Family Practice Residency seeks a sixth full-time physician for the position of Assistant/Associate Director. We are expanding to add three Rural Training Track programs. The La Crosse-Mayo program has a 21-year history of training family physicians and is one of the premiere programs in the upper Midwest. Applicants must be American Board of Family Practice certified and experience in teaching is a plus. Extremely competitive salary and benefit package. Send CV to Thomas J. Grau, MD, Program Director, La Crosse-Mayo Family Practice Residency, 700 West Avenue South, La Crosse, WI 54601 or call Physician Services at 1-800-269-1986.

ASPEN Medical Group

Full Time Urgent Care

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

according to a study by HealthSystem Minnesota's Oncology Research Department published in the May 15 issue of *Cancer*.

The study found that men who had radical prostatectomies had more trouble with sexual function, with 70 percent reporting impotency, compared with 50 percent of men who had radiotherapy. Of the men who had surgery, 52 percent reported urinary dysfunction versus 15 percent of those who had radiotherapy. Bowel dysfunction was more common following radiotherapy, with 21 percent of men reporting diarrhea weekly versus 8 percent of the men who had surgery.

The study is based on data collected from 132 prostatectomy patients and 142 men who underwent radiotherapy at Methodist Hospital. Respondents completed a questionnaire assessing the occurrence and severity of specific changes in bowel, urinary, and sexual function and evaluating their quality of life one to five years after treatment.

"Such information can be extremely useful in assisting physicians as they counsel patients in the selection of the preferred course of treatment," said **Cheryl L. Shrader-Bogen, R.N.**, one of the study's researchers.

HIV Triple Therapy Dramatically Cuts Virus Levels

A regimen of three anti-HIV drugs reduces amounts of virus stored in lymph tissue by 99.9 percent after six months, according to a study led by University of Minnesota researchers and published in the May 9 issue of *Science*. The triple therapy was already known to reduce virus in the blood to near-undetectable levels, but the new study shows similar results against virus stored in tonsils.

Led by virologist **Winston Cavert, M.D.**, the researchers counted HIV viral particles using a technique developed by **Ashley Haase, M.D.**, head of the University of Minnesota microbiology department. The technique allows scientists to visually locate and count HIV-infected immune cells and copies of viral RNA contained in particles in tonsilar tissue. The researchers measured the virus in tonsil tissue from 10 previously untreated HIV-positive adults who underwent therapy with three drugs: the protease inhibitor ritonavir and the reverse transcriptase inhibitors zidovudine and lamivudine.

The researchers found that in the early days of treatment, about half of infected CD4s (T helper cells) that were producing new virus disappeared in only 0.9 day. It took only 1.7 days to clear half the viral particles from the follicular dendritic cells. After three weeks, the rate of disappearance slowed but still continued at a strong pace. In most patients, some viral RNA remained detectable after six months, but in one patient, viral RNA dropped to undetectable levels. Cavert cautioned, however, that the virus can also exist in latent form as DNA—made from the RNA blueprint that constitutes the core of the virus; even the patient in whom HIV RNA had disappeared had at least some residual viral DNA.

ATP May Be Pain Messenger

Adenosine triphosphate (ATP), a common molecule known as the "energy currency" of cells, appears to be the substance that signals the nervous system to register pain, according to researchers from the University of Minnesota and Oregon Health Sciences University. The discovery may lead to effective pain medications that would prevent the nervous system from receiving messages from the molecule. The study appears in the May 29 issue of *Nature*.

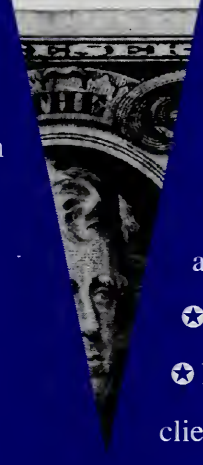
Long known as the prime energy broker for cells, ATP has only recently gained acceptance by scientists as a transmitter of messages to the nervous system, said **Robert Elde, Ph.D.**, dean of the University of Minnesota's College of Biological Sciences. The molecule is found in every cell and is leaked when cells are damaged. The leaked ATP comes into contact with pain-sensing neurons, sending a pain signal to the brain. MM

DID YOU KNOW THAT MMBR'S EMPLOYEE BENEFITS TEAM CAN HELP YOU

BRIDGE THE GAP

Did you know that MMBR, the resource company owned by the Minnesota Medical Association and Hennepin Medical Society, can really help you with the challenges of providing employee benefits?

That's right. Because providing services to medical professionals is our only specialty, you can be sure that MMBR will do a great job in helping you design and obtain quality benefit plans for your practice.



Join the many other medical practices who count on MMBR for employee benefit plans such as:

- ✪ Group medical, dental, disability and life coverage
- ✪ Qualified retirement plans
- ✪ Educational personal finance seminars for your employees
- ✪ Personal financial reviews for physicians and staff
- ✪ Voluntary benefits such as life, disability, and long term care insurance
- ✪ Payroll deduction auto and home insurance
- ✪ Free COBRA administration for MMBR group clients

We work to make bridging the gap convenient and cost effective.

Call Barry Weber or Dan Hagberg today at

800-298-6627

MMBR

Minnesota Medical Business Resources
Owned By MMA & HMS

VITALIS

(continued from page 7)

the experience she gains there also helps her in her work here, she says. Moreover, urgent care departments experience seasonal fluctuations in patient volume. "We appreciate the flexibility if some people want to not be working during other parts of the year," says Peitzman. "That actually helps us."

So with the summer urgent care rush over in Minnesota, Vitalis headed back to Somalia in September 1993, planning on a six-month tour of duty. But by December 1993, Mogadishu was in turmoil. At one point, armed soldiers threatened one of Vitalis's clinics. She and other aid workers soon pulled out of Somalia, and she finished her stay in the southern Sudanese village of Ulang.

Vitalis had never been to a more remote locale: no electricity, no telephones, no money, few motor vehicles. Many villagers had never seen white skin. In fact, many pitied Vitalis because they assumed her blond hair was a different shade of gray, and they couldn't understand why such a young woman had aged so quickly.

Sudan had been fighting a civil war since 1988, and even in this remote village, Vitalis felt the effects. A man who was seriously injured from picking up a land mine in his village walked all day to the Ulang clinic for treatment. Still, most of Vitalis's work was similar to that in Somalia: infectious diseases and malnutrition. A relapsing fever spread by head lice was treated with tetracycline and a massive insecticide campaign. Tuberculosis and malaria were common. "And snake bites and crocodile bites," she says. "We don't see much of that at Park Nicollet."

One morning in March 1994, a man came to Vitalis's tent and warned her that armed men from a rival tribe were coming toward the village in a violent cattle raid. A half hour later, she heard gunfire. "We radioed the U.N. base in Lokichokio [Kenya]," recalls Vitalis, but no planes were available for evacuation. She and clinic staff went to a shelter but soon came out to treat the wounded. After three tense hours, Vitalis heard a U.N. plane approaching; she and the clinic volunteers were evacuated moments later. "Twenty-five people were killed that day in Ulang," she adds, "and the raiders returned two days later to burn down the village."

When she tells the story, a somber tone replaces Vitalis's normally buoyant voice. As she stood on the airstrip waiting to board the plane, a woman from the village ran up to her, carrying a young girl. "She tried to give me her 3-year-old daughter to take with me, to get her out of the fighting." Vitalis pauses. "I couldn't. And I have really struggled with my decision for a long time. Should I have taken her? Did I do the right thing? So, it was a hard departure. ... The feelings of 'here we are abandoning them,' even though we knew we were no good to them dead. ... That was a hard transition back," she admits of her return to suburban urgent care. "All of a sudden, sore throats weren't so desperate."

In the spring of 1995, Vitalis made her fourth trip to Africa, this time to Kigali, Rwanda, several months after the massacre of hundreds of thousands of Tutsi and Hutu. Her goal was to get Kigali's community hospital up and running in the aftermath of war and to establish a clinic at a nearby orphanage. In addition to the infectious diseases she'd seen in other countries, war-related and motor vehicle injuries were common. Because local doctors and nurses could do much of the hands-on work, Vitalis contends that her medical contribution was less crucial than in Somalia or Sudan. "I felt [my purpose] was more bringing in a sort of positive force, a light in the darkness."

Vitalis's commitment to mission work is clear. Not that she feels a need to proselytize or preach, but she is strongly dedicated to helping those in need. She speaks of the pervasive sense of oppression in Rwanda. "I felt it getting off the plane," she says. "There is so much evil." Even the nonreligious would have to agree. "The atrocities that were done, not just killing someone, but cutting them into little pieces with machetes ... and throwing infants in the air and chopping them up as they come down," says Vitalis, recalling horrors of the war. "I did not sleep well in Rwanda." Still, she was committed to serving.

"The best thing about Susan, the strongest thing about Susan, is her tremendous capacity for compassion," says Michael Van Rooyen, M.D., head of the Office of International Health Studies at the University of Illinois' Department of Emergency Medicine. "She cares so much about helping people, and she puts herself in uncomfortable and sometimes dangerous situations to do that."

It was Van Rooyen, a part-time physician for Samaritan's Purse, who called on Vitalis again when a doctor was needed for Bosnia's reconstruction efforts. Vitalis left for Sarajevo in March 1996. "The devastation in the city is incredible," she says. The clinic she helped rebuild had been used as a headquarters by Serbs, and they'd stripped it clean when they left. "Pipes, toilets, sinks. They tore a wall out to take the x-ray machine." Undaunted, Vitalis quickly helped assess needs and wrote grants for support to improve local medical care.

And then, the fateful basketball game. Recounting the play that cost her a ligament, Vitalis insists that she did block the pass. "I jumped up to catch the ball. Then I came down and turned to dribble. It was just the wrong force, and it snapped my knee."

After months of physical therapy, Vitalis is anxious to get back on her feet. But the injury hasn't kept her from volunteering. When Fargo was flooded in April, she took care of her nieces so that her sister and brother-in-law could help stem the river's destruction. "I was frustrated that I couldn't sandbag, but it worked out great baby-sitting," she says. Still, it will be some time before Vitalis boards a plane for another overseas mission. "To go to these places," she says without irony, "you have to be able to run." MM

Douglas Clement is a free-lance writer in Minneapolis.

JACOBSON

(continued from page 9)

groups in Africa. The Maasai are a conservative group of cattlemen, living much as they have for centuries. They hold a world view based on relationships and reconciliation. For a Maasai, to be healthy is to be "whole." To be whole means in healthy relationships with God the creator, with one's neighbors, and with the environment.

Illness is understood ultimately to result from broken relationships. In fact, much of our ill health *is* a result of broken relationships. Diseases related to environmental degradation abound. Here in Africa, diarrhea caused by contaminated water is clearly a broken relationship with our environment. How people live with their fellow human beings also determines health. Consider physical abuse, or abuse of the poor by the rich. The diseases I most commonly confront in Africa are diseases of poverty—diarrhea, malaria, malnutrition, measles, tuberculosis. African medicine treats the maladies of the poor, while Western medicine treats the maladies of the affluent. Further yet, consider the scourge of HIV and AIDS; 80 percent of those affected live in the developing world, while 95 percent of the expenditures on HIV and AIDS are made in the developed world. AIDS is often spread as a result of broken relationships, in part because of broken economies.

Most Africans understand that all life is spiritual. When ill health is about, the means to return to wholeness must be sought. Because illness results from brokenness, healing can only take place when relationships are reconciled and restored. So in Africa, the healer is perceived as a spiritual guide and healer who restores not only the body but also the soul.

Such a world view has a profound impact on how Western scientific medicine is practiced. If I am an effective healer, it is only because I am gifted by God. My patients—traditionalists, Muslims, and Christians—expect that as a healer, I am a person of faith and spirit and that I will pray with them. Moreover, many will simultaneously seek care from a traditional healer even as they come to our Western-model hospital.

This world view also demands a wholistic approach to health. For this reason, we at Selian have developed the Maasai Health Project, a community health effort that promotes both health and development. As we work in 75 villages in the highlands of Tanzania, we seek the language to integrate the concepts of health and development.

I have often used as an example the story of teaching village women how to prevent diarrhea. At one time, our group explained the need for boiling drinking water, frequently washing hands and bathing, and properly disposing of waste. Yet changes were not implemented. We were puzzled—until we realized that women in the villages were already working 18 or 19 hours a day and that boiling water meant carrying another load of firewood from the forest a few kilometers away. More washing meant hauling more water from the stream or spring. Proper waste disposal required rulings from the larger community, over which the women were not in control. Generally, the problem is not a lack of knowledge, but rather constraints—social, cultural, economic, religious, and gender—that prevent the application of knowledge. We cannot affect health without simultaneously affecting the human development of those we serve. Health and development are so intimately intertwined that we no longer speak of them separately in our work. Together they have become "Uzima," the Swahili word for "wholeness."

HEALTH CARE FINANCING

Though our hospital continues to be filled with exotic trauma and an unending variety of tropical disease, the major issue before us is not unlike that in Minnesota: how to finance health care. The dilemma facing Selian Lutheran Hospital is how to be faithful to a Christian mandate to serve the poor, indeed the poorest of the poor, while attempting to become financially more self-reliant. Our patient fees cover only 60 percent of the hospital's running costs. Even so, traditional donors for such work are increasingly calling for Third World hospitals to become self-sufficient. Support is decreasing, and charity hospitals are beginning to feel the uncomfortable squeeze. How will we survive? Although our average charge for a day of hospitalization is only $3, it is a major expense to people whose per capita income is only $200 and a day's wage is $1.50. To raise our charges allows us to survive, but it would mean treating only the wealthy of our community, leaving the poor without care.

In search of a solution, I have turned to my Minnesota experience. Selian has begun the first HMO in Tanzania! With a thousand prepaid members recruited through employers in our community, we are beginning to assure ourselves of a paying clientele, enabling us to generate enough income to serve the poor. The program is growing rapidly, and we already need to open a satellite clinic to be more accessible to our health plan members. A surgeon friend of mine suggested that we call our program "Blue Spear/Blue Shield," but we haven't quite dared.

Running this wonderful hospital in Africa is a never-ending joy. The joy comes from hope—hope that the people we serve will know wholeness, reconciliation, and health; the challenge of studying and learning within so many disciplines; the opportunity to serve others in need; the honor of being accepted into another culture. The miracle of touching so many lives daily is indeed a gift, and I am grateful to be able to share a glimpse of my life as a doctor in Africa.

Sincerely,

Mark Jacobson
Arusha, Tanzania
Mjacobson@habari.co.tz

Mark Jacobson was raised in Stillwater, Minnesota, and graduated from the University of Minnesota Medical School. He also has a master's in public health from Johns Hopkins.

CHILD LABOR

continued from page 13

international trade is a cultural imposition. Despite international convention, however, in many areas of the world, large numbers of children start working at a young age (see Table 1).

The Prevalence of Child Labor

Even in nations that maintain good vital statistics, estimating the number of working children is difficult. In the United States, for example, child employment data are gathered only for children 16 and older, and the hours of work are not reported.[7,8] Thus, it is not surprising that developing and undeveloped nations lack good data on child labor practices.

Until 1996, the ILO estimated that approximately 150 million children worldwide worked; the current estimate is 250 million.[6] However, even this figure may be low. For example, there are an estimated 1.1 billion children between ages 5 and 16 in developing nations and the least developed nations of the world.

Table 1

*Age of compulsory education compared with minimum age for employment and completion of fifth grade for select nations**

Country	Age for compulsory education	Minimum age for employment†	Percent of children reaching grade 5 1990-1995‡
India	14	14	62
Nepal	11	14	52
Mexico	14	14	84
Nicaragua	12	14	54
Morocco	14	12	80
Egypt	15	12	98
Pakistan		14 to 15 by industry sector	48
Bangladesh	10	12 to 15 by industry sector	47

*Data used in this table were selected to show a range of problems as well as different regions of the world. Additional data are available for many other nations.

†Source: International Labour Office. Child labour: law and practice. Conditions of Work Digest 1991;10:1-223.

‡Source: Bellamy C. The state of the world's children. Oxford: Oxford University Press, 1997.

In many nations, fewer than 50 percent of children complete a primary school education (see Table 1). Secondary school enrollment is considerably lower. Conservatively, if 50 percent of children in developing nations do not attend school and if most of these children work, the number of working children may be closer to 500 million—a number not significantly different from Ferguson's estimate of 410 million out-of-school children.[9]

Although impaired by a lack of comprehensive data, researchers have found that children spend long hours at work and often have little or no time away from the workplace. Table 2 shows the number of hours 360 children worked in Lahore, Pakistan.[10] In a study of 210 Malaysian children, the children worked an average of 10 hours per day. Thirty-eight children reported that they worked seven days per week, and 132 had only a half day off per week.[11] The World Health Organization reported similar work hours for children in Sudan and Turkey,[11] and Asogwa reported similar data for Nigeria.[12]

The Health Effects of Child Labor

The health effects of child labor in developing nations are many, but good data are hard to find. Additionally, many referenced reports published in other nations are difficult to obtain. Several studies on the general health of child laborers exist but tend to be small or have poorly defined control groups. The studies also fail to clearly define their study groups and how specific diseases were diagnosed.

These study design problems are substantial in regions of the world where sanitation is poor, waste control promotes waterborne disease, the accumulation of garbage attracts vermin, and medical care is sporadic or not available.[13] To my knowledge, no one has studied the impact of specific occupational exposures on young workers' health, either in the United States or abroad.

The health impacts of child labor fall into four categories: 1) the effect of work on growth and develop-

ment; 2) job-specific hazards that lead to injury and illness, including ergonomic exposures and acute and chronic environmental exposures; 3) the effect of latency (time from exposure to disease onset) on the future health of children; and 4) sexual, other physical, and emotional abuse. This report does not address in any detail the forms of abuse to which child workers are exposed. The few reports that exist indicate that child abuse within the workplace is a serious problem for girls, who frequently do domestic work. Following is a discussion of the first three categories.

Growth and development

Perhaps the most obvious health impact of child labor is on intellectual development. A strong positive correlation exists between child labor and adult illiteracy.[14] Epidemiologic studies have also found a strong relationship between severe child malnutrition and lack of maternal education. In a case control study of approximately 500 Bangladeshi women,[15] children of mothers with no education had a tenfold increase in risk of severe malnutrition when compared with children of educated mothers. This risk was significantly higher than the risk of illness imparted by bottle feeding instead of breastfeeding (odds ratio=3.3). Maternal illiteracy has also been associated with low birthweight.[16]

Early pregnancy is also a major obstacle to improving the socioeconomic status of women because girls and young women usually quit school if they become pregnant. Although girls and women are generally marrying at an older age than they have for many decades, 50 percent of African women, 40 percent of Asian women, and 30 percent of Latin American women still marry before age 18.[9] This contrasts with an average marrying age of 23 years for women in industrialized nations.

According to Ferguson,[9] regardless of such factors as socioeconomic status and accessibility to health care, a woman who has attended school for even a few years is more likely than an uneducated woman to marry later, seek prenatal care, have a smaller family, and have healthy children.

Table 2

*Average hours of work per day by age and type of work for 360 children in Lahore, Pakistan**

Type of work	Under 9 years†	9 to 11 years†	Over 11 years†
Automobile	10	12	12
Carpet	8	10	10
Lathe machine	10	0	9
Hotel	12	12	10
All	8.5	9	9.8

*Source: Ahmed A. Child labor in Pakistan: a study of the Lahore area. Child Welfare 1991;70:261-7. Not all categories of work are included due to space limitations.

†Although not explicitly stated by the authors, it appears that children under 9 years of age represented 8 percent of the sample; those 9 to 11 years of age, 28 percent of the sample. The remainder were 11 years or older.

Table 3

*Medical conditions found during the examination of 210 working children in Malaysia**

Condition†	Males	Females	Total
Anemia	59	29	88
Stomatitis	39	19	58
Enlarged liver	35	14	49
Ankle edema	15	8	23
Underweight	69	32	101

*Source: World Health Organization (WHO). Children at work: special health risks. WHO Technical Report, Series 756. Geneva: WHO, 1987.

†Not all conditions are listed due to space limitations. Boys had an average of 2 conditions and girls an average of 2.7 conditions.

Table 4

*Disease patterns in north Indian child laborers in the organized and unorganized labor sectors of the economy**†*

Condition	Organized Sector (%)	Unorganized Sector (%)
Nutritional deficiency	61.5	93.05
Tuberculosis	23.2	26.0
Intestinal parasitosis	83.6	86.7
Skin infections	43.0	63.4
Diarrheal diseases	32.1	51.9
Injuries	32.5	19.3
Miscellaneous	12.0	17.8

*Source: Gupte S. Child labor [Letter]. Indian Pediatr 1987;24:176-7.

†This study did not specify the number of children surveyed, nor did it define organized and unorganized labor. Numbers are presented as a percent of the total.

Poor health among working children is reflected in most studies that have tried to evaluate this problem.

Several studies have surveyed the general health of child workers.[11] Table 3 describes the general health of a group of 210 working children in Malaysia. Table 4 describes the general health of a group of children working in north India (the study did not report the number of children involved). In a study of 45 working children in Tel Aviv,[17] 19 (42 percent) had visible signs of poor health. These included poor teeth, paleness, short stature, and a malnourished appearance. Almost 17 percent of the children reported that they did not attend school.

Job-specific hazards

Working children may be exposed to a diversity of hazards in such jobs as pumping leaded gasoline, cutting rock in stone quarries, tanning leather, electroplating metals, scavenging garbage for food, and tending goats and sheep. Studies have examined the impact of a variety of substances on children's health. For example, children are more likely than adults to absorb lead, and they are also at greater risk of developing irreversible neurologic damage from the exposure.[10] Studies on the impact of mercury and carbon monoxide indicate both substances retard early growth and development. These substances are also well-documented reproductive hazards.[18]

Although children frequently work in occupations with well-defined and disease-related exposures, most are offered little or no protective equipment. Even when it is available, this equipment is virtually useless because it is designed for adults.

No epidemiologic studies have been conducted that address the impact of specific work-related exposures on the health of children. There are several reasons for this: First, children are often working illegally. Second, children are rarely the beneficiaries of any type of labor contract. Third, such studies are expensive and difficult to conduct.

Latency effects

Although there are no data on the long-term exposure of children to environmental hazards, it is possible to develop disease models that examine the impact of latency on the early development of disease. A child who begins work at a young age has many more years to develop a problem compared with adults who have similar exposure. Silicosis, closely linked to the development of tuberculosis, is a worldwide problem that provides a disconcerting example of the effect of latency on the early development of disease.[11]

In India, two industries with a reportedly high prevalence of child laborers—stone cutting and slate pencil manufacture[19]—also have a high prevalence of silicosis. Thirty-five percent of the stonecutters and 55 percent of the pencil workers have silicosis. Studies of workers in Indian potteries have shown the prevalence of silicosis and tuberculosis to be similar—approximately 15 percent. In some pottery-related occupations, the prevalence of silicosis was as high as 32 percent.[20] Furthermore, the overall prevalence of tuberculosis in the pottery industry was reported to be at least tenfold greater than for India's overall population. The mean duration of exposure prior to the diagnosis of silicosis for individuals in this industry may be only 20 years vs. more than 30 years for an iron molder.[21]

Children also commonly work in brick factories and granite quarries. Especially risky for children are granite-crushing facilities, where the silicosis prevelence may be as high as 75 percent.[22] Grundorfer and Raber describe 18 cases of silicosis; of these, seven (39%) had silicotuberculosis.[22] Given the extraordinary levels of dust exposure, these workers may have a mean latency of less than a decade before the onset of silicosis.[21]

As with many exposure-related diseases, the dose-response relationship between level of exposure and the development of silicosis appears to be linear, with silicosis developing within a few months or over a lifetime. The changes that occur with silicosis are most likely if the onset of exposure is at a relatively young age and exposure continues. Even after exposure to silica stops, the disease will likely progress. Those who begin

work at a young age are likely to suffer from silicosis at a correspondingly early age. The relationship between silicosis and tuberculosis has been known for many decades;[23] the incidence of tuberculosis increases with more severe silicosis.[24] Young workers appear to be at significant risk of developing silicotuberculosis and other diseases as a result of their type of work but also as a result of their generally poor nutritional status, poor level of health care, and typically cramped and poorly ventilated work environments.

Organizations Addressing Child Labor Issues

Many Minnesota and national organizations are working to understand and resolve problems related to child labor. Minnesota Advocates for Human Rights is emphasizing child labor during the upcoming year. The Minneapolis-based Resource Center of the Americas has labor programs that examine labor rights, and the University of Minnesota Center for Human Rights Education has programs for teaching about human rights. National consumer programs are underway to identify with the RugMark® label goods children did not make. Consumers and schools should also inquire about the origin of sporting goods. Those made in Pakistan may well have been made by children.

Conclusion

Not only is child labor an abuse of basic human rights, robbing young children of their formative years, but it also poses significant health hazards. Young workers are at substantial risk of developing both work-related and nonwork-related illness. Most data indicate that the health status of young workers is poor. All too often, these health problems are compounded by intolerable work conditions. Although data on the toxic effects of occupational exposures to children are limited, existing disease models amply support the hypothesis that children will develop disease at an early age as a result of their work.

Sadly, the abuses don't end with health hazards. This article doesn't even discuss the physical, emotional, and sexual abuse child laborers endure, nor does it discuss child prostitution or the use of child soldiers, two of the most intolerable forms of child exploitation.

Health care workers, especially those who are involved with corporations doing international work, can help combat the problems associated with child labor. The medical community should pressure corporations to examine the source of all their products and to develop a comprehensive policy for helping children make the transition from work to school. Health care workers should also encourage communities to examine their own tolerance for the exploitation of children both at home and overseas. MM

David Parker is an occupational epidemiologist at the Minnesota Department of Health and an occupational health physician at HealthSystem Minnesota. He also is an author of the book, "Stolen Dreams: Portraits of Working Children," written for children in grades four through nine. The book, which also appeals to older readers, will be published this month by Lerner Publications in Minneapolis.

Address reprint requests to David L. Parker, M.D., M.P.H., Minnesota Department of Health, 717 Delaware Street SE, Minneapolis, MN 55414. For information related to the exhibition of child labor photographs, Dr. Parker may be reached at 612/623-5220 during business hours.

REFERENCES

1. Wiener M. The child and the state in India. Princeton, New Jersey: Princeton University Press, 1991.
2. Derickson A. Making human junk: child labor as a health issue in the progressive era. Am J Public Health 1992(8):1280-90.
3. Parker DL, Engfer L, Conrow R. Stolen dreams: portraits of working children. Minneapolis: Lerner Publications, 1997.
4. International Labour Office. Child labour: law and practice. Conditions of Work Digest 1991;10:1-223.
5. U.S. Department of Labor, Bureau of International Affairs. By the sweat and toil of children: the use of child labor in American imports. Washington, D.C.: U.S. Department of Labor, 15 July 1994.
6. Bellamy C. The state of the world's children. Oxford: Oxford University Press, 1997.
7. U.S. Department of Labor, Bureau of Labor Statistics. Employment and earnings. Washington, D.C.: U.S. Department of Labor, March 1996;43(10):227,232.
8. Parker DL, Carl WR, French LR, Martin FB. Nature and incidence of self-reported adolescent work injury in Minnesota. Am J Ind Med 1994;26:529-41.
9. Ferguson BJ. Youth at the threshold of the 21st century: the demographic situation. J Adolesc Health 1993;14:638-44.
10. Ahmed A. Child labor in Pakistan: a study of the Lahore area. Child Welfare 1991;70: 261-7.
11. World Health Organization (WHO). Children at work: special health risks. WHO Technical Report, Series 756. Geneva: WHO, 1987.
12. Asogwa SE. Sociomedical aspects of child labor in Nigeria. Am J Occup Med 1986;28: 46-8.
13. Asthna S. Variations in poverty and health between slum settlements. Soc Sci Med 1995;40:117-88.
14. Raju T. Child labour, adult literacy and employment rates in India. Indian J Pediatr 1989;56:193-200.
15. Islam MA, Rahman MM, Mahalanabis D. Maternal and socioeconomic factors and the risk of severe malnutrition in a child: a case-control study. Eur J Clin Nutr 1994;48: 416-24.
16. Cleland JG, van Ginneken JK. Maternal education and child survival in developing countries: the search for pathways of influence. Soc Sci Med 1988;27:259-72.
17. Feingold E, Wasser J. Walk-through surveys for child labor. Am J Ind Med 1994;26:803-7.
18. Faden R. Reproductive health hazards in the workplace. Washington, D.C.: Office of Technology Assessment, 1985.
19. Harvey P, Riggin L. Trading away the future: child labor in India's export industries. Washington, D.C.: International Labor Rights Education Fund, 1994.
20. Saiyed HN, Ghodasara NB, Sathwara NG, Patel GC, Parikh DJ, Kashyap SK. Dustiness, silicosis, and tuberculosis in small scale pottery workers. Indian J Med Res 1995;102:138-42.
21. Ahlmark A, Bruce T, Nystrom A. Silicosis from quarrying and working of granite. Br J Ind Med 1965;22:285-90.
22. Grundorfer W, Raber A. Progressive silicosis in granite workers. Br J Ind Med 1970;27:110-20.
23. Jones JG, Owen TE, Corrado HA. Respiratory tuberculosis and pneumoconiosis in slate workers. Br J Dis Chest 1967;61: 138-43.
24. Cowie RL. Short course chemotherapy with rifampicin, isoniazid and pyrazinamide for tuberculosis evaluated in gold miners with chronic silicosis: a double-blind placebo controlled trial. Tuber Lung Dis 1996;77: 239-43.

Compare your personal insurance coverages to Atlantic Mutual's

(and then call MMBR Insurance Agency at 800-298-6627).

This plan is administered for the members of the Minnesota Medical Association by:



The Christensen Group

Them.* Us.

	Them*	Us
Medical Professional Endorsement	NO	YES
Loss of Wages	$50/Day	$500/Day
On-Residence Business Property Coverage	$2,500	$25,000
Off-Residence Business Property Coverage	$250	$10,000
Electronic Apparatus Coverage	$1,000	$2,500
Computer Records Coverage	NO	$5,000
Umbrella Coverage Available up to $10 Million	NO	YES
Non-Profit Directors and Officers Coverage	NO	YES
Scheduled Property Covered as Valued	NO	YES
Total Loss Cash Settlement Option	NO	YES
Water Back-Up Coverage	NO	YES
Mortgage Renegotiation Coverage	NO	YES
Lock Replacement Coverage	NO	YES
Worldwide Fine Art Coverage	NO	YES

*Based on ISO standards



MMBR

Minnesota Medical
Business Resources
Owned By
MMA & HMS

Bottom line, you pay insurance premiums to get the best coverage. One way to make sure you're getting the best coverage is to buy a personal insurance policy that's designed for you.

Atlantic Mutual Insurance Company's Atlantic Master Plan, combined with our Medical Professional Endorsement, covers almost all of your precious possessions in one policy. You get coverage for up to three homes, seven cars, jewelry, furs, fine art and boats. And, you get extra time to tell us about newly acquired vehicles, boats and other valuables.

Compare your personal insurance policy to Atlantic Mutual's. Then contact MMBR Insurance Agency, Inc., 3433 Broadway St. NE, Suite 375, Minneapolis, MN 55413. Phone 800-298-6627 today.

AtlanticMutual Companies

Excellence in property and casualty insurance since 1842.

This advertisement contains only a general description of coverages and does not include all the benefits and limitations found in the policy. The insurance policy and not this descriptive advertisement will form the contract between the insured and the insurance company.

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

JULY 1997

Jul. 13-19 **Mayo Clinic Internal Medicine Board Review 1997** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jul. 14 **Diagnosing Breast Cancer: A Team Approach to Early Detection** Minnesota Medical Association and Midwest Medical Insurance Company; St. Luke's Hospital, Duluth, MN. CONTACT: Robin Houlihan, Midwest Medical Insurance Company, 6600 France Avenue South, Suite 245, Minneapolis, MN 55435; 612/922-5445 or 800/328-5532.

Jul. 20-22 **Update in Otolaryngology: Head and Neck Surgery** Mayo Foundation; Skamania Lodge, Stevenson, WA. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Jul. 24-26 **Management Strategies in Hematology** Mayo Medical Laboratories; Whistler, British Columbia. CONTACT: Julie McAdams, Mayo Medical Laboratories, 200 First Street SW, Rochester, MN 55905; 507/284-8599.

Jul. 29-31 **Third Annual Mayo Multidisciplinary Symposium on Platelets, Blood Vessels, Biomaterials, and Transfusion** Mayo Foundation; Rochester, MN. CONTACT: Registrar, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jul. 31-Aug. 2 **Bleeding and Thrombosing Diseases: Back to the Basics** Mayo Medical Laboratories; Rochester, MN. CONTACT: Mayo Medical Laboratories, Office of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/533-1710 or 507/266-4373, or fax to 507/284-4542.

AUGUST 1997

Aug. 9 **Advanced Phacoemulsification Techniques** Phillips Eye Institute; Minneapolis, MN. CONTACT: Leslie Gibson, Phillips Eye Institute, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061; fax 612/870-0315; E-mail gibson@allina.com

Aug. 10-12 **Success with Failure: Evaluation and Treatment of Congestive Heart Failure** Mayo Foundation; Vail Cascade Hotel and Club, Vail, CO. CONTACT: Registrars, Mayo Foundation, Office of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Aug. 15-16 **Optimizing Disease Management Through Pulmonary and Gas Exchange Diagnostics** University of Minnesota Continuing Medical Education; Sheraton Washington Hotel, Washington, D.C. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Aug. 15-16 **Statistical Computing** Hennepin County Medical Center; Cragun's Resort, Brainerd, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Aug. 21-23 **Medical Directors Training Program** University of Minnesota Continuing Medical Education; The Historic Brown Palace Hotel, Denver, CO. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

SEPTEMBER 1997

Sept. 5-6 **Orthotics and Prosthetic Symposium: A Multidisciplinary Approach to Orthotic and Prosthetic Management** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 8 **Ettinger Lecture (Neurology)** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 8-11 **Counseling the Compulsive Gambler: Phase II** Minnesota Council on Compulsive Gambling; New Orleans, LA. CONTACT: Elizabeth M. George, 314 West Superior Street, Suite 702, Duluth, MN 55802; 218/722-1503.

Sept. 12-13 **Advanced Trauma Life Support Course** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Sept. 12-14 **Annual Ambulance Medical Directors Retreat** Hennepin County Medical Center; Radisson Arrowwood, Alexandria, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 800/263-4262.

Sept. 19 **Contemporary Issues in Hemodialysis** Hennepin County Medical Center; Sheraton Midway Hotel, St. Paul, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 19 **Second Annual Regional Ob/Gyn Conference** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Sept. 19-20 **Mayo Clinic Update in Hepatology and Liver Transplantation 1997** Mayo Foundation; Minneapolis Hilton and Towers, Minneapolis, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 19-20 **Midwest Glaucoma Symposium** Phillips Eye Institute; Marriott City Center, Minneapolis, MN. CONTACT: Leslie Gibson, Phillips Eye Institute, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061; fax 612/870-0315; E-mail gibson@allina.com

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142

E-Mail: stephanie.l.jussila@qm.healthpartners.com



Central Minnesota Group Health Plan

HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220

Wilderness Charm and Cosmopolitan Amenities

St. Mary's/Duluth Clinic Health System, a 300-physician multispecialty group, with 3 hospitals and 22 neighborhood & regional centers serving a referral population of 460,000, seeks physicians in the following areas:

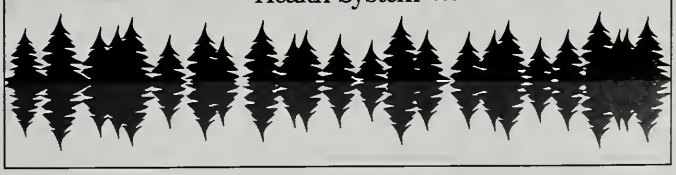
EP Cardiology	**Orthopedic Surgery**
Dermatology	**Ophthalmology-Retina**
Emergency Medicine	**Pathology**
Family Practice	**Pediatrics**
Internal Medicine	**Psychiatry – Adult**
Nephrology	**Psychiatry – Child**
Neurosurgery	**Rheumatology**

We offer a complete compensation package, including excellent fringe benefits and generous vacation/CME time. Only here can you listen to a duet of loons and a symphony orchestra in the same evening.

Contact Mike Griffin Marci Jackson or Jocelyn Heid, SMDC, 400 E. 3rd St., #500, Duluth, MN 55805 or call 1-800-342-1388 or fax 218-722-9952 or e-mail to: sr@smdc.org

SMDC

St. Mary's/Duluth Clinic Health System *eoe*



Sept. 19-20 **Through the Eyes of Others: Envisioning Culturally Competent Healthcare** Hennepin County Medical Center; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 21-23 **Echocardiography for the Sonographer 1997: Focus on Valvular and Myocardial Disease** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 21-25 **Advances in Diagnostic Radiology** Mayo Foundation; The Empress Hotel, Victoria, British Columbia. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 24-26 **Advanced Radiology Life Support Course** Mayo Foundation; The Empress Hotel, Victoria, British Columbia. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 26-27 **Statistical Computing** Hennepin County Medical Center; Brainerd, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 26-28 **The 1997 Interim Meeting of the Society for Pediatric Pathology** Society for Pediatric Pathology; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Cathy Vaidich, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/813-6711.

OCTOBER 1997

Oct. 2-3 **Annual Forensic Science Seminar** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 2-3 **Meeting the Challenges of Rural Cancer Care** St. Mary's/Duluth Clinic Health System; Duluth, MN. CONTACT: Mary Connolly, Educational Services, St. Mary's/Duluth Clinic, 400 East Third Street, Duluth, MN 55805; 218/726-4434 or fax 218/726-4273.

Oct. 2-3 **Research Statistics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 9-10 **Annual Orthopedic and Trauma Seminar** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

STILLWATER
MEDICAL GROUP, P.A.

Be a part of a rapidly growing community in the historic city of Stillwater, MN.

An opportunity is available for a board certified physician in General Surgery in the scenic St. Croix River Valley.

- 42-physician, multi-specialty clinic, with two clinic locations in Stillwater, MN
- Comprehensive benefit package
- Excellent school system
- Ideal for families
- Located near the banks of the beautiful St. Croix River

If interested please call or send CV attention:
Liz Junker, H. R. & Benefit Specialist
921 S Greeley St.
Stillwater, MN 55082
(612) 439-1234 Ext. 327

FAMILY PHYSICIANS

The University of Minnesota Department of Family Practice and Community Health is seeking physician faculty for its state-of-the-art community residency program clinic affiliated with North Memorial Medical Center. Teaching, administrative, and full-range family practice clinical duties. Attractive benefits package. ABFP, MN license, teaching experience. Call for full description and qualifications, (612) 624-2401, or view our Web page at:

http://www.med.umn.edu/fp

The University of Minnesota is an Equal Opportunity Educator and Employer.

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., July 15 for September ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

Olmsted Medical Center is seeking BC/BE physicians in family medicine. Great opportunity for well-trained physicians to join a 75-physician multispecialty group in a dynamic, progressive practice. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes 10 branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (*5/96-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Part-time Neurologist wanted for multidisciplinary office, no call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Urgent Care Physicians: We are a growing urgent care practice looking for BC/BE physicians to work full or part time to staff our four clinics. We currently have three locations in the metro area and one location in Mankato and are planning on expanding in 1997. Please contact Cara Auge at 612/593-9818 or 800/511-2820 for more information on joining our growing practice, or send inquiries to 9800 Shelard Parkway, #210, Plymouth, MN 55441. (4/97-R)

Manitowoc, Wisconsin: The Manitowoc Clinic, a member of the Aurora Health Care system, is seeking a general internist to join our 16-physician multispecialty group. Guaranteed two-year salary and excellent benefits package. Contact, or send CV to, James Robinson, Administrator, Box 1270, Manitowoc, WI 54221-1270. Telephone 414/682-8841. 3-7/97

Urgent Care Physicians: Opportunities for BC/BE family practitioners. St. Francis Medical Center in Shakopee, 30 minutes southwest of Minneapolis, is opening an urgent care at the hospital in May 1997. Evening and weekend hours are available for permanent positions or moonlighting. A second location in Chaska, 10 minutes northwest of Shakopee, is opening August 1997. Paid malpractice. Contact Debbie Modder, Allina Health System, Route 81465, 5601 Smetana Drive, Minnetonka, MN 55343; 612/992-3094 or 800/248-4921. 4-7/97

Olmsted Medical Center: A 75-physician multispecialty group practice is searching for qualified physicians to complement the emergency medicine staff (variety of shifts available). Our Level II emergency department has an annual volume of 18,000 patients and advanced technology to provide the highest quality care. Excellent salary and malpractice insurance coverage provided. Contact: Lois Till-Tarara, Olmsted Medical Center, 1650 4th Street SE, Rochester, MN 55904; 507/287-2430. *3-7/97

Medical Office available for rent in St. Louis Park, September 1, 1997. Exam equipment, furniture, x-ray unit, and processor available at deep discount. Call Sheilagh, 612/540-0015. *2-7/97

Affiliated
COMMUNITY
Medical Centers, P.A.

Join the security of a large multispecialty group located in Southwest and West Central Minnesota Communities of 3,700 to 19,000. All areas flourish with four-season recreational opportunities, strong economies and excellent education where family and lifestyle are a priority. Outstanding benefits for BE/BC physicians in:

Dermatology	Neurology
Family Practice	Ob-Gyn
Internal Medicine	Orthopedic Surgery

Contact: Janiece Durham
Physician Recruitment Coordinator
Affiliated Community Medical Centers
101 Willmar Avenue SW
Willmar, Minnesota 56201-3591
320-231-6366

Practice to Take Over: Well-established internal medicine practice in downtown Minneapolis. Large patient base. Well-equipped for internal medicine. COLA certified laboratory. In-office computerized billing system. Nominal charge for equipment and goodwill. The incoming physician is expected to be busy from day one. Ideal for new residency graduate who has an ambition to be independent or to start own group. Will introduce. Forward all inquiries to: Minnesota Medical Association, Box 864, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. 4-7/97

Luther Midelfort–Mayo Health System: A thriving 160-physician multispecialty clinic and hospital in Eau Claire, Wisconsin, is seeking a BC/BE family practitioner for our Chetek, Wisconsin, office. A desire to practice ob/gyn is essential. General call of 1:10 and ob/gyn call of 1:7 is expected. Physicians do not have first call in the ER. A newly remodeled office will be shared with one other family practitioner. Chetek, located 40 miles north of Eau Claire, is in the heart of resort country. Located on a chain of six connecting lakes, Chetek offers four-season recreation for the outdoor enthusiast. For further information, contact Christie Blink, Physician Recruitment Coordinator, at 800/573-2580, or fax 715/838-6688. *3-7/97

Green Bay, Wisconsin–Prevea Clinic: An 80-plus physician-owned, multispecialty clinic is expanding its internal med-

ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 32-physician multi-specialty group currently recruiting additional physicians in the following specialties:
- DERMATOLOGY
- PEDIATRICS
- INTERNAL MEDICINE

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

Neurologist,
Oncologist,
Urgent Care

There are immediate openings at Brainerd Medical Center for a Neurologist, an Oncologist, and an Urgent Care physician.

Brainerd Medical Center, P.A.
- 35-Physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162 bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota
- Surrounded by the premier lakes of Minnesota
- Located in central Minnesota less than 2 ½ hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:
- Curt Nielson
  (218) 828-7105
  or (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

icine department to meet growing patient base in a 200,000 community with a strong work ethic located in beautiful northeastern Wisconsin. 1:8 call. Contact Karen Van Gemert, 800/236-3030, or fax CV to 414/431-3043. Not a J-1 opportunity. *3-8/97

Urgent Care–Wausau, Wisconsin: Finding an exceptional practice can be more time-consuming than paperwork. That's why there's Wausau Medical Center! If you're concerned about lifestyle, that's why there's Wausau, Wisconsin. Wausau Medical Center, located in Central Wisconsin, is a busy, well-established multispecialty group practice of 70 physicians. Currently, we're seeking to add two physicians to our seven-physician Urgent Care Department, which has experienced 11 consecutive years of solid growth. Here, you'll enjoy the distinct advantages that Wausau and the surrounding area have to offer, such as all-season recreation, outstanding schools (including two- and four-year college campuses), low-low crime rate, easy access to major urban areas, a diverse economic base, and much more! If you're interested in an exceptional practice in an exceptional community, come home to Wausau, Wisconsin! Please call or send CV to James Lombardo, Director of Physician Resources, 715/847-3239, Wausau Medical Center, 2727 Plaza Drive, Wausau, WI 54401. 1-7/97

Emergency Medicine: Full-time and moonlighting positions available at Lakeview Hospital in Stillwater, Minnesota. Eight thousand patients per year. Low acuity, excellent back-up and remuneration. Great opportunity for emergency medicine or family practice residents to pick up added income and experience. Also, multispecialty group looking to add third ED/urgent care physician. Contact Tom Monahan, M.D., Stillwater Medical Group, P.A., 612/437-1234. *2-7/97

Beautiful New Doctor's Office Space–Bloomington: Easy access, great location, 12th floor, wonderful views, big windows, free covered parking. Psychiatrist seeking M.D. to share space. All business office functions provided. Contact Jerry Jacobsen, 612/801-4536. 1-7/97

Wanted: Internal Medicine Specialist to provide medical expertise as an in-house consultant for the Social Security disability program in Minnesota. BC is not a requirement. Must be currently licensed in the state of Minnesota. Located in downtown St. Paul. Work must be provided on the premises. Fifty-four dollars per hour, up to 20-plus hours of work per week available immediately. Great flexibility in work schedule. Free parking in the Robert Street ramp. Excellent working conditions. Very stable work opportunity. Earnings are exempt from the MinnesotaCare 2 percent provider tax. Please contact William T. Ruhl, Assistant Director, Medical Services, MN Disability Determination Services, Suite 300 Metro Square, St. Paul, MN 55101; 612/296-4419. *2-7/97

FAMILY PRACTITIONERS: ARE YOU LOOKING FOR...

A CHALLENGING CLINICAL PRACTICE?

- Join 3 F.P. and 2 N.P. in a clinic with 25,000 annual patient visits
- Financially stable 31-bed hospital, 74-bed LTC, and HH agency
- Access to 26 outreach specialists
- Including Operative, Obstetric and Emergency Services

A GOOD LIFE?

- Working flexible 4.5 day week with 1:4 weekend and night call
- A progressively diverse rural community
- Within two hours of Fargo and Sioux Falls and three hours of Twin Cities
- Recreation: Big Stone Lake, 18-hole golf course, National Wildlife Refuge

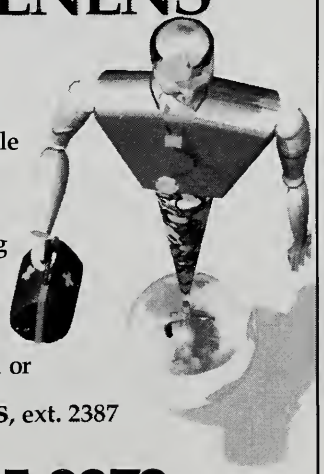
A SUPPORTIVE COMMUNITY?

- Community-based Health Care Foundation with $1 million dollars pledged
- Providing competitive package including:
  - Guaranteed starting salary w/incentive
  - Two year housing allowance
  - Educational loan repayments

C.V. in confidence to Fred Peterson, Admin.,
Ortonville Area Health Services,
Ortonville, MN 56278.
Phone: (320)839-2502; FAX: (320)839-2507. EOE.

Staff Care, Inc.
"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS



- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging

Ask for :
John Moberly, ext. 2381 or
Melanie McReynolds, ext. 2387

(800) 685-2272
http://www.locumsnet.com

Staff Care is proud to sponsor
the Country Doctor of the Year Award

Unable to place J-1 or H-1 physicians

Luther Midelfort–Mayo Health System: A thriving 160-physician multispecialty clinic and hospital in Eau Claire, Wisconsin, is seeking two BC/BE general internists. Positions are open in the Eau Claire and Chippewa Falls offices. Call of 1:6, competitive compensation and benefits package, and a stable work environment are only a few of the benefits of these positions. Eau Claire is a university community of 60,000 people, 90 minutes east of Minneapolis/St. Paul. Contact Christie Blink at 800/573-2580, or fax 715/838-6688. *3-7/97

Orthopedic Surgery: Physician-owned group located near Minneapolis seeks an orthopedic surgeon. Community offers impressive growth, lakes nearby, good school choices, and a safe environment. Practice offers ready patients, top compensation, state-of-the-art equipment, and adjoining hospital/clinic facilities. Call Verne Meyer, 800/967-2711, or fax CV to 320/587-7252; E-mail: delacore@hutchtel.net 1-7/97

Family Practice: BC/BE to join progressive 31-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographic referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Scott D. Ellingson, M.D., or Janet M. Bergeron, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AOA/EOE. *4-9/97

Minnesota Medicine

AN EXCELLENT ADVERTISING INVESTMENT

Target marketing pays real dividends with your space advertising in ***Minnesota Medicine,*** the official journal of the Minnesota Medical Association.

Delivered directly to offices, hospitals, and clinics, ***Minnesota Medicine*** reaches your key clients and prospects in their business setting.

For complete advertising information contact:

Sherry Makela
Minnesota Medicine
3433 Broadway Street NE, Suite 300
Minneapolis, Minnesota 55413

612/378-1875

800/DIAL MMA

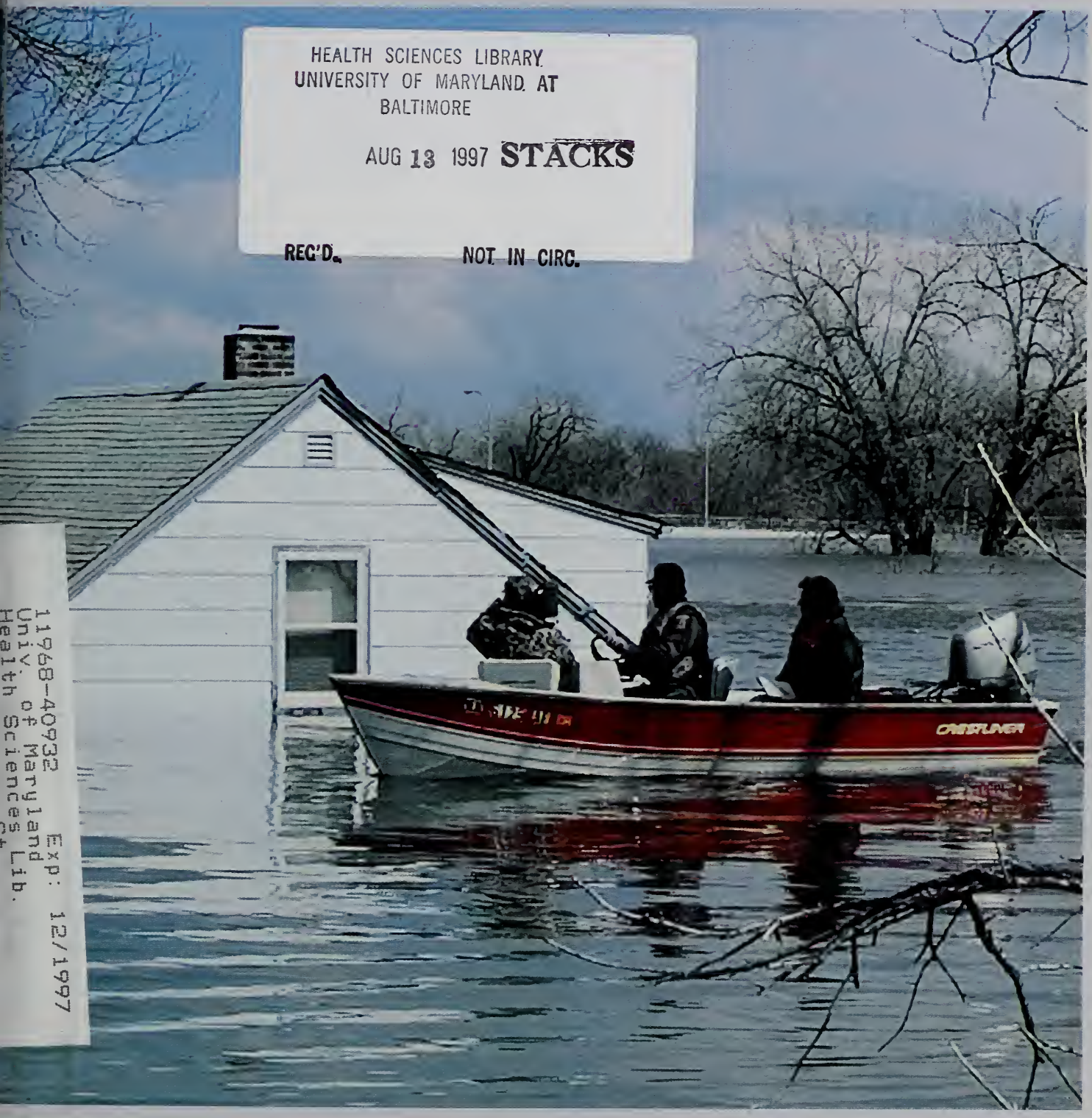
JULY 1997 INDEX TO ADVERTISERS

Affiliated Community Medical Centers 62
Alexandria Clinic, P.A. 62
Allina 24
Aspen Medical Group 48
Bone, Muscle & Joint, Inc. 31
Brainerd Medical Center 62
Centeon Bio-Services 43
Central Minnesota Group Health Plan 59
Chisago Health Services 19
Fairview Clinic Services 46
First Call Physicians, Inc. 47
Franciscan Skemp Healthcare 48
Gillette Children's Specialty Healthcare 4
HealthEast–Bethesda ..... Cover 2
Hennepin County Medical Center ..... Cover 3
Hennepin Faculty Associates 31
Hudson Physicians 43
Leonard, Street & Deinard 43
Medical Protective Company 25
Midwest Medical Insurance Co. 32
MMBR 41, 49, 56-57
Multicare Associates of the Twin Cities 30
Norwest Center 30
Ortonville Area Health Services 63
Paster Enterprises 19
PMIC, Inc. 24
St. Mary's/Duluth Clinic Health System 59
St. Paul-Ramsey CME 31
Staff Care, Inc. 63
Stillwater Medical Group 60
THC Minneapolis 5
University of Minnesota ..... Cover 4, 60
Wenatchee Valley Clinic 30, 47
Whitesell Medical Locums, Ltd. 43

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE
AUG 13 1997 STACKS
REC'D. NOT IN CIRC.

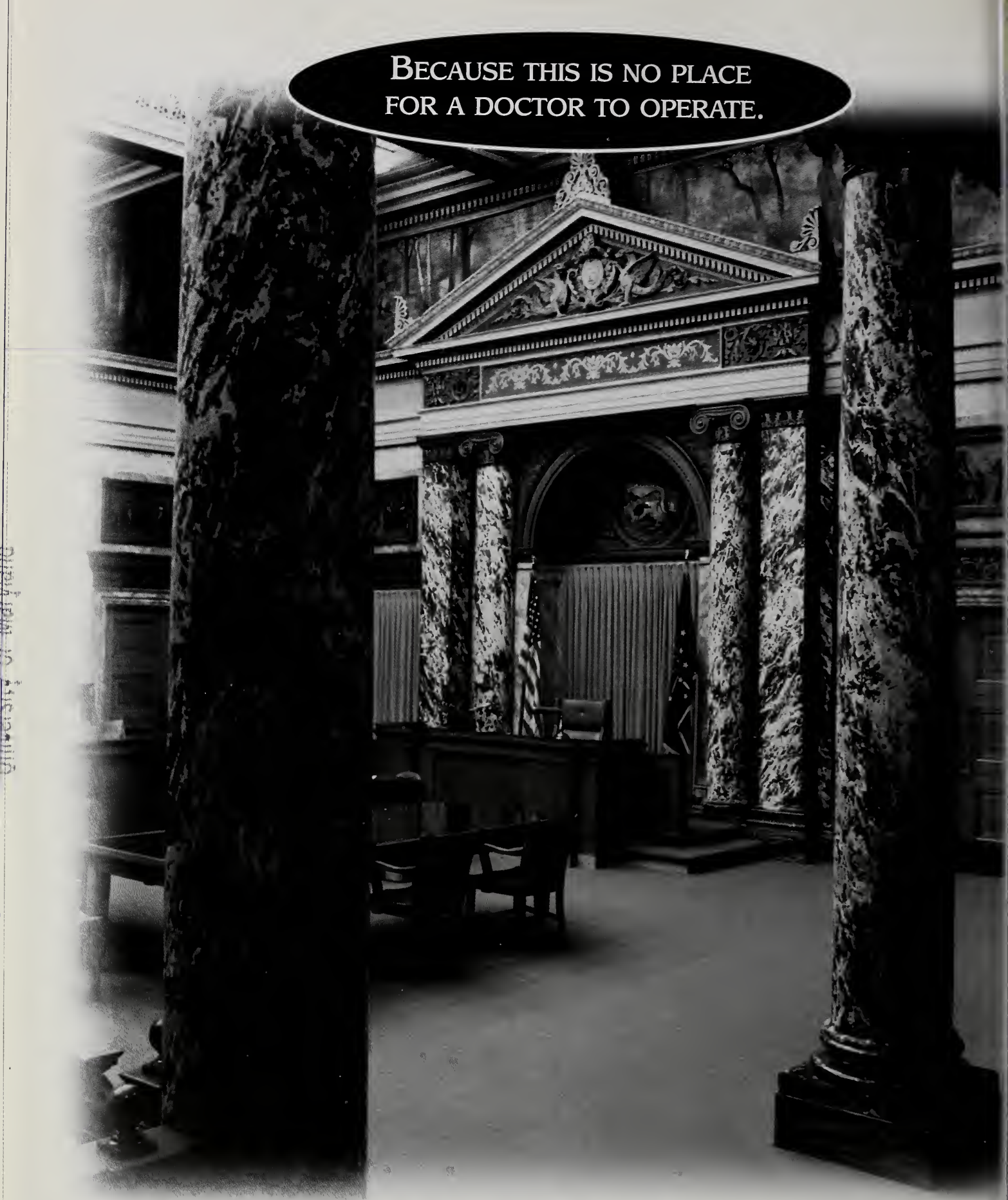


11968-40932 Exp: 12/1997
Univ. of Maryland
Health Sciences Lib.

Floodwaters

Physicians Join the Fight

AUGUST 1997



THE
MEDICAL PROTECTIVE COMPANY ®

Professional Protection Exclusively since 1899

To reach your local office, call 800-344-1899.

GOLD CORPORATE AFFILIATE
MGMA
FOUNDED 1926
PROGRAM UNDERWRITER

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

The Point neighborhood of East Grand Forks on April 19. Copyright 1997 Star Tribune/ *Minneapolis-St. Paul.*

DEPARTMENTS

2 ..... Editor's Notebook

6 ..... Media Watch

42 .... Author Instructions

51 .... News Clips

58 .... CME in Minnesota

61 .... Classified Ads

64 .... Index to Advertisers

FACE TO FACE

8 **Split Shift** ..... Jeremiah Christopher Whitten
Neal Holtan, M.D., M.P.H., practices clinical medicine in the morning and sets public health policy in the afternoon.

PERSPECTIVES

12 **Waging a Noble War against a River** ..... Kenneth R. Carter, M.D., and Darrell L. Carter, M.D.
Granite Falls community members joined forces to save their city from the rushing waters of the Minnesota River.

FEATURE STORIES

14 **Floodwaters Bring Physicians to the Front** ..... Karen M. Stensrud
Amid the chaos of the 1997 floods, Thomas Cariveau, M.D., set up a MASH-like clinic to care for East Grand Forks residents.

20 **A Partnership for Public Health**
Medicine and public health team up to combat modern ills.

PUBLIC HEALTH REPORT

25 **Public Health Response to the 1997 Minnesota Flood: Lessons Learned** ..... Agnes T. Leitheiser, R.N., M.P.H., Mary Rippke, R.N., M.S., Mary Sheehan, R.N., M.P.H., Jack Korlath, M.P.H., and Buddy Ferguson
The Minnesota Department of Health helped flood-ravaged communities provide essential services.

CLINICAL & HEALTH AFFAIRS

29 **Five Years of Work-Related Injuries and Fatalities in Minnesota: Agriculture—a High-Risk Industry** ..... Margaret Brown, M.P.H., David Parker, M.D., Elizabeth Seeland, B.S., Debora Boyle, D.V.M., Ph.D., and George Wahl, M.S.

43 **Tetanus: A Case Report** ..... Ann C. Sudoh, B.A.

BOOK REVIEWS

47 **Managing Disaster** ..... Reviewed by James N. Logue, Ph.D., M.P.H.
A review of "The Public Health Consequences of Disasters," edited by Eric K. Noji, M.D.

49 **The Power of Raging Waters** ..... Reviewed by Charles R. Meyer, M.D.
A review of "Rising Tide: The Great Mississippi Flood of 1927 and How It Changed America," by John M. Barry.

33 The Monitor

Highlights ..... *Geographic Coalition action on Medicare*
• *Highlights of the 1997 AMA Annual Meeting*

Public Health: Aseptic, Not Boring

Public health is dull. Or so I thought. Oft-told stories of tuberculosis and malaria loll with mesmerizing epidemiological statistics that only a mathematician could love. The ambiguities of parts-per-million and questionable causality seem so much messier than nice clean heart attacks and diabetes. And besides, with the victories of Salk and Sabin, public health is a dying specialty. Right? Wrong! Like most areas of medicine, public health is a vibrant field whose current face is almost unrecognizable from its turn-of-the-century mien. This month *Minnesota Medicine* recognizes public health as disease finder, disease preventer, and health promoter.



"Public health may lie at the fulcrum of medicine's future."

The roots of public health lie in the sanitation movement of the late 19th century, when dirt and something vaporous called "miasma" were believed to cause disease and contagion. The revelations of Koch and Pasteur heralded the golden age of microbiology and the genesis of modern public health. As the 20th century progressed, medical science seemed to be amassing a perfect record against microbes as we learned about vectors with malaria, prevention with polio, and global eradication of disease with smallpox. However, tenacious opponents appeared with the advent of AIDS and other organisms resistant to our tricks.

Despite unresolved infectious disease challenges, public health diversified. From bugs, it branched out to environmental, social, and personal behavior threats to our species. Well-documented environmental dangers of radium on clock dials and black smog in London in the early 1990s seemed simple next to later, muddier threats like radon and electromagnetic fields. Since the '70s, public health advocates have trumpeted the impact of income, living conditions, and violence on health. And in the '50s, Framingham, birthplace of the risk factor, became an icon for studying personal habits and their tie to disease and health.

Interesting historical stuff, but surely public health is different from clinical medicine? After all, it uses strange tools like questionnaires and tick nets. It studies large populations rather than individuals. It must battle political and cultural forces whether it is trumping the smallpox goddess in India, responding to Communist conspiracy allegations in the fluoride controversy, or wrangling with state legislators for public health dollars. And many public health efforts, like the yellow fever campaign in Panama, take on a distinct militaristic bent.

But clinical medicine and public health do share important common space. Both are increasingly multidisciplinary. Both must grope for important connections. Both must fastidiously pursue detail. And both must grapple with irrational barriers to getting the job done—like men who won't use condoms to prevent STDs, or patients whose fears of cancer make them difficult to help.

So maybe public health is not so dull. Indeed, it may lie at the fulcrum of medicine's future. Schools of public health are advancing the science of decision analysis and outcome study, which promise to give clinicians new insights into what we do for our patients. As Harvey Fineberg, dean of the Harvard School of Public Health, said: "We will never in this world solve health problems one person at a time."

Practicing physicians still do have to solve one person's problems one at a time. But they can draw on the wisdom of our public health colleagues, whose job, according to William Foege of the Carter Center, is "to be indignant on behalf of everyone" while they define and prevent disease and promote health.

–Charles R. Meyer, M.D., Editor-in-Chief

For a readable summary of major public health issues in this century, I recommend "The People's Health: A Memoir of Public Health and Its Evolution at Harvard," by Robin Marantz Henig.



DaShon's Story

When DaShon was struck by a car, the 5-year-old ended up with a brain injury and severely broken leg. He found the care he needed at Gillette Children's Specialty Healthcare.

Gillette Children's Pediatric Brain Injury Program has doctors, nurses and therapists who specialize in rehabilitation for children. We also have pediatric orthopaedic surgeons. All within one hospital.

With continued therapy at Gillette Children's, DaShon will soon be out of his wheelchair and back to being an active 5-year-old boy.

If you or someone you know has a child with special medical needs, call Gillette Children's.

For 100 years, we've been creating new stories every day about our care for kids with chronic conditions.

Since 1897...

Gillette Children's
Specialty Healthcare

An Essential Community Provider

For more information, contact Gillette Children's Specialty Healthcare: (612) 229-3851.

- Cerebral palsy and other neuromotor delays
- Brain and spinal cord injuries
- Complex orthopaedic conditions
- Spina bifida
- Juvenile arthritis
- Epilepsy
- Chronic pain
- Technology dependency (children who breathe on ventilators)

"I wanted to be a doctor for as long as I can remember. Before I started school, my family would send me across the street to use the phone to call a doctor when my grandmother was ill. The entire family looked forward to his visit. After he was there, my grandmother got better.

"That struck me . . . the doctor helped her and she got better."

Although it's a child's image of medicine, it's one I will always cherish though we can't always help patients become well. Working with medical students and residents has been an unexpected reward for me. It's gratifying to be approached by practicing physicians with whom I was involved in their medical training. They will pull me aside and tell me they remember how I approached a patient or specific things that I said years ago . . . and how what I shared has helped them in their practices. For me, helping patients get well and contributing to the medical education of future doctors are very satisfying parts of this profession."

Henry T. Smith, M.D.
Internal Medicine • Hennepin Faculty Associates
Division of Internal Medicine

HMS Hennepin Medical Society



Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editors
Lee J. Engfer
Susan Rodsjo

Assistant Editor
Juliet Ramotar

Public Health Reports Editor
Barbara Yawn, M.D., M.Sc.

Graphic Designers
Lee Engfer
Mike May
Susan Rodsjo

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine.* The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/DIAL MMA (342-5662).

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff

Editors Emeritus
Edmund C. Burke, M.D.
1991-1993

Richard L. Reece, M.D.
1975-1990

Reuben Berman, M.D.
1971-1974

Carl O. Rice, M.D.
1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine.* Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1996-97 Officers

President
Raymond G. Christensen, M.D.

President-Elect
Kent S. Wilson, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Paul R. Hamann, M.D.

Secretary
Judith F. Shank, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Anthony C. Jaspers, M.D.

Vice Speaker of the House
Blanton Bessinger, M.D.

Past President
Michael J. Murray, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Kendra Flanagan

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth Crabb, M.D.
Theodore L. Fritsche, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/DIAL MMA (342-5662).

Fax: 612/378-3875.

E-mail: mma@mnmed.org

Web site: www.mnmed.org

CONTINUING MEDICAL EDUCATION

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

SEPTEMBER, 1997

16-17 ADVANCED TRAUMA LIFE SUPPORT
Presented by: Allina Health System
Location: United Hospital, St. Paul

19 MIDWEST GLAUCOMA SYMPOSIUM
Presented by: Phillips Eye Institute
Location: Marriott Hotel - City Center, Minneapolis

19-20 CLINICAL APPLICATIONS OF BEHAVIORAL MEDICINE: TREATMENT OF PSYCHOPHYSIOLOGICAL DISORDERS
Presented by: Allina Medical Group Mental Health Services
Location: Minneapolis Marriott Southwest Hotel, Minnetonka

26 PAIN DISSEMINATION CONFERENCE
Presented by: Allina Health System
Location: Radison Hotel South & Plaza Hotel, Bloomington

OCTOBER, 1997

15 SUDDEN DEATH & ATHLETES
Presented by: Minneapolis Heart Institute Found.
Location: Hyatt Regency Hotel, Minneapolis

17 ADVANCED LIFE SUPPORT IN OBSTETRICS (ALSO)
Presented by: Allina Health System
Location: United Hospital, St. Paul

For more information, contact
Allina Clinical Education - (612) 992-2424

™ A Trademark of Allina Health System

Visit the Allina CME calendar on our Home Page at http://www.allina.com

Emergency Physicians

Our busy Emergency Medicine Department at the St. Paul-Ramsey Medical Center has flexible, part-time opportunities for BC/BE Emergency Medicine physicians. A variety of shifts are available. Excellent salary and malpractice insurance coverage is provided.

Our state-of-the-art 31 room emergency facility has an annual census of 57,000, a 20% admission rate, an EM residency program and a department staff of 16 emergency medicine faculty, seven physician assistants, an administrator and support staff.

For consideration, forward your CV to: HealthPartners, Physician Services, Attn: Sandy Lachman, P.O. Box 1309, Minneapolis, MN 55440. Or fax to (612) 883-5395. For more information, call (612) 883-5338 or e-mail: sandy.j.lachman@healthpartners.com. No agencies, please. EO/AA Employer

HealthPartners
St. Paul-Ramsey Medical Center
HealthPartners' mission is to improve the health of our members and our community

Announcing the opening of Bone, Muscle & Joint Inc.'s Midwest Regional Development Office

BMJI is a single specialty musculoskeletal Physician Practice Management (PPM) company.

BMJI assists with the business operations of your practice, restoring the pleasure of being a physician.

Bone, Muscle & Joint's Philosophy...

- Majority Physician Ownership
- Physician/Practice Autonomy
- Physician & BMJ Interests Fully Aligned
- Managed Regional Operating Teams
- Managed Care Network Development
- Focus On Worker's Comp



Bone, Muscle & Joint, Inc.

For more information call 1-800-414-BMJI (2654)
or in the Midwest 1-630-904-8232



KSTP-TV Investigative Report Sells Fear, Not Facts

On its 10 o'clock news segment May 21, KSTP-TV ran an "investigative" report on doctors who have been cited by the Board of Medical Practice (BMP) yet are "allowed" to practice with local HMOs. The piece included all the tawdry techniques we have come to expect from yellow journalism—flashes of syringes, EKGs, emergency rooms, aggrieved victims, and the "bad" doctor evading reporters. Excerpts from a BMP citation of a neurosurgeon were projected over pictures of the involved patients and quotes from the patients' relatives. Throughout the feature, an ominous-looking video cutout of the doctor floated across the patients' photos. Partial-sentence sound bites from relatives and from ethics guru Arthur Caplan punctuated the coverage.

Any communication—written, audio, or video—has two fundamental components: factual content and impression. The factual content is the building block from which the story is constructed. The impression—the take-home message—is molded by how the facts are presented. The presentation can, and should, make the objective data more interesting and understandable. Advertising communication adds a diverting twist: it presents the product but it "sells" something else. Tobacco companies present cigarettes but sell machismo and sex. Car companies present automobiles but sell machismo and sex. (Is there a pattern here?)

With the advance of video technology and the shortening of the American attention span, TV journalism has learned that "talking heads" reciting news stories are more soporific than Dalmane. Grabbing market share is crucial for generating advertising revenue, especially during that bizarre rite of sweeps week, so TV news media have increasingly geared up their video effects to enhance and dramatize the message. They have borrowed from their advertising cousins and sold something beyond factual content. The soaps have taken over the 10 o'clock news.

What was the take-home message of the KSTP broadcast? Because I am a less-than-objective observer (even though I know only one of the doctors mentioned), I asked the closest nonmedical person available—my wife—to analyze the broadcast. My wife's medical knowledge consists of whatever she gleans from our evening social hour. Her medical expertise is slightly greater than my piano-playing ability (her specialty). She is, however, an intelligent and analytical person. I asked what she got from the KSTP report. She answered, "Fear." I asked what she knew about those doctors after the report and she said, "I'm confused. I don't know."

What was the factual content of the KSTP piece? The BMP had cited three doctors for different misdeeds. These doctors were currently practicing medicine and were credentialed to do so by various local HMOs. These two statements formed the basis of the video spectacle. Likely the KSTP team took two publicly available lists, BMP actions and HMO provider lists, and found matching names.

What got lost in the sound bites and the flashing syringes was important background information: What does the BMP do, and what do its actions mean? The BMP is an important, deliberative body that polices physicians' activities. It has extensive power and, I believe, attempts to be cautious in its execution of that power. Doctors sanctioned by the board are usually given opportunities to rehabilitate themselves and return to practice. I know the details of several doctors' rehabilitation; the requirements are quite

arduous. A physician who returns to practice has completed rehabilitation to the BMP's satisfaction. HMO credentialing relies partly on the BMP's blessing to grant a physician privileges.

Supplying this background would have informed the public. It would have made the doctors' cases more understandable. But it would have made a non-story.

Maybe the neurosurgeon should not be practicing. But to prove that beyond mere innuendo, KSTP would have to do intricate legwork. Rather than gather additional facts and possibly inform us, they chose to scare and confuse us. MM

"Media Watch" is an occasional column written by Minnesota Medicine*'s editor-in-chief, Charles R. Meyer, M.D., an internist with Consultants–Internal Medicine in Minneapolis.*

IT'S TIME WE CLEAR THE AIR...TOGETHER.

SMOKE FREE 2000

COALITION

For more information please call 612-338-8193.

The Right Care . . . The Right Setting . . . The Right Time



As an extended, critical care hospital focusing on the acutely ill, medically complex patient, THC · Minneapolis aggressively transitions patients to the most appropriate level of care, whether that be a skilled nursing home, subacute facility or home health care. Such was the case with Mr. Ayott, 47 years old, who suffered severe injuries to his chest and lungs in a disastrous car accident. After being stabilized at an acute care hospital, Mr. Ayott transferred to THC to undergo ventilator weaning, wound care, and physical and occupational therapy. With a successful weaning rate of 78% and a new inpatient pulmonary program, THC made it possible for Mr. Ayott to receive the right care in the right setting at the right time.

THC Minneapolis

A Subsidiary of Transitional Hospitals Corporation

612-588-2750

Medically Complex Program · Pulmonary/Ventilator Program
Wound Care Program · Low Tolerance Rehabilitation Services

Split Shift

Neal Holtan, M.D., M.P.H., defies stereotypes by practicing clinical medicine in the morning and setting public health policy in the afternoon.

By Jeremiah Christopher Whitten

Say the word "lawyer," "politician" or "doctor" and most people immediately form an image in their minds. Just ask Neal Holtan, a St. Paul physician who works in two different worlds and is the subject of more than one stereotype.

In the morning, you will find Neal Holtan, M.D., at St. Paul-Ramsey Medical Center's International Clinic, where he practices internal medicine and sees 10 to 15 patients before noon.

What do public health people think of clinical physicians? Holtan furrows his brow: "They see clinical physicians as obsessed with technology and focused on using expensive interventions for people who are dying anyway."

Each afternoon, Holtan sets down his stethoscope, takes off his lab coat, and drives to his downtown St. Paul office, where he becomes, in the eyes of some people, a bureaucrat. Neal Holtan, M.P.H., spends his afternoons as medical director of the recently merged St. Paul-Ramsey County Department of Public Health.

What do clinical physicians think of public health administrators? Holtan laughs: "They think we're all mushy headed—the health care equivalent of tree-huggers."

Holtan admits these are extreme characterizations, but he is uniquely qualified to make such observations. As a practicing physician who is also a public health administrator, he works in both worlds. Finding a balance between the two disciplines is sometimes difficult.

"The skills are very different," Holtan says. "A practicing physician who's seeing a patient is not worried about consensus building or community outreach. The clinician is worried about the patient's immediate and long-term needs. That's all that's important at that point in time. The clinician has to focus on the patient or there will be adverse consequences.

"That is not true from a public health approach," continues Holtan, who has been a medical director with St. Paul Public Health since 1987. "Focusing on the individual is actually detrimental because you lose the big picture. You need to know the scope of the disease in the population, who's affected, how it's transmitted, and how to intervene in the transmission of the disease, rather than the treatment of the disease once it occurs."

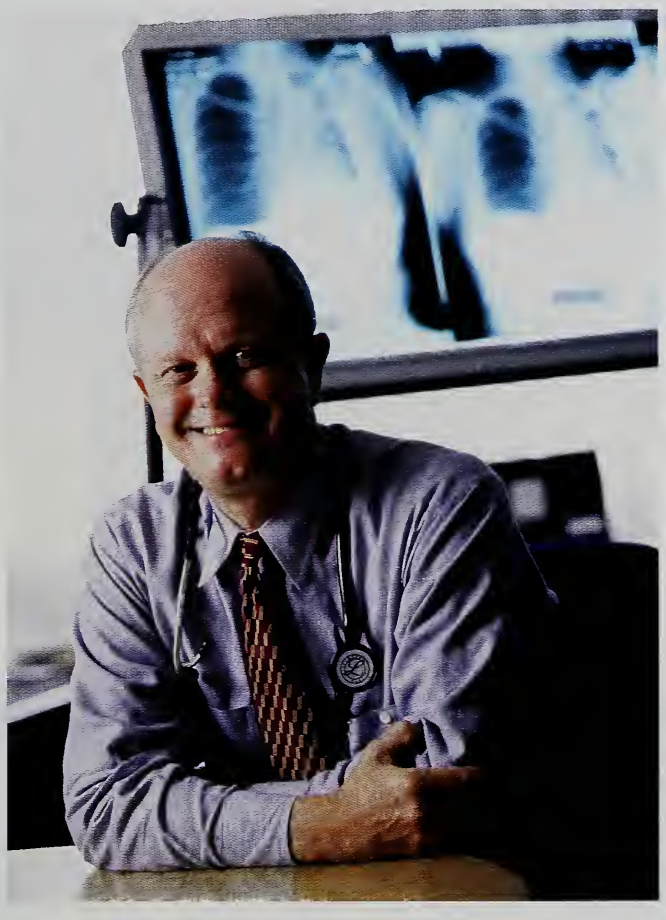
Some observers see a tension between clinical medicine and public health administration, but the man who works in both worlds says the two disciplines are important partners in the treatment of illness and disease.

"Clinicians see problems first," Holtan says. "The entire public health system depends upon clinical

University of Maryland Library

physicians to be an early warning system. Physicians bring attention to problems and ask for solutions.

"At that point," says Holtan, "the public health system kicks in with its skills and resources. It might do an investigation and assessment of the problem, looking at epidemiology, who's affected, the size of the problem, interventions, costs, and results. Then you start moving toward prevention."



PHOTOGRAPH BY JOHN NOLTNER

Prevention is important to Holtan personally and professionally. As a young child just over a year old, Holtan developed polio. He was sent away for three months of treatment and didn't recognize his own mother when she came to take him home. By the time he was 10 years old, Holtan had undergone half a dozen operations on his leg to restore his mobility.

Holtan's decadelong rehabilitation as a child still motivates him as an adult. Delivering the commencement address at the University of Minnesota School of Public Health last year, Holtan stood before an audience of more than 650 people and described how his experience with polio affected his life.

"In 1948, as a 15-month-old child, I had just learned to walk. My mother put me to bed one evening and in the morning she set me on the floor and I fell over. My left leg was paralyzed. ... I have a very strong respect for the researchers who find vaccines for diseases such as polio and for the practitioners who bring preventive measures to families and people. These experiences gave me a vision of what I wanted to do with my life. In whatever way possible, I wanted to help people escape from disease that could have been avoided and misery that could have been spared."

Holtan has devoted his career to helping people escape disease. Since graduating from medical school at the University of Iowa in 1973, he has been part of a generation of physicians and public health officials who have made enormous strides in medicine and public health. Holtan is proud that so many diseases have been eliminated or brought under control in his lifetime, but he is dismayed to see some diseases returning, such as tuberculosis.

At the International Clinic, Holtan sees patients with TB, treating their symptoms and focusing on one successful outcome at a time. At his St. Paul public health office, Holtan looks at how TB affects an entire population and helps design prevention programs, such as citywide testing of schoolchildren.

As a public health administrator, Holtan is mindful of the political climate that surrounds the resurgence of tuberculosis. "It takes resources to control TB, and the resources weren't in place in the early 1980s. We took it for granted," Holtan says. "There was a very strong anti-government strain that burst on the national scene in the 1980s, with tax-cutting, government-bashing, and reliance on the private sector. We let the public health system in New York City decay to the point where it was almost invisible. [The system] didn't have the resources to deal with TB, so TB came back. It's as predictable as rain."

Holtan's frustration with the political and economic climate is obvious. That's one of the reasons he cofounded the Minnesota Council for Preventive

Medicine in 1993. "I think many physicians feel that preventive medicine hasn't been emphasized enough," he says. "There are too many barriers. We don't have a managed care system right now—we have a *managed cost* system. Preventive medicine, as much as people talk about it, is rarely practiced. I think physicians want another forum for talking about preventive medicine other than a billing and economic system. We don't care who pays for it—we want prevention included in the system."

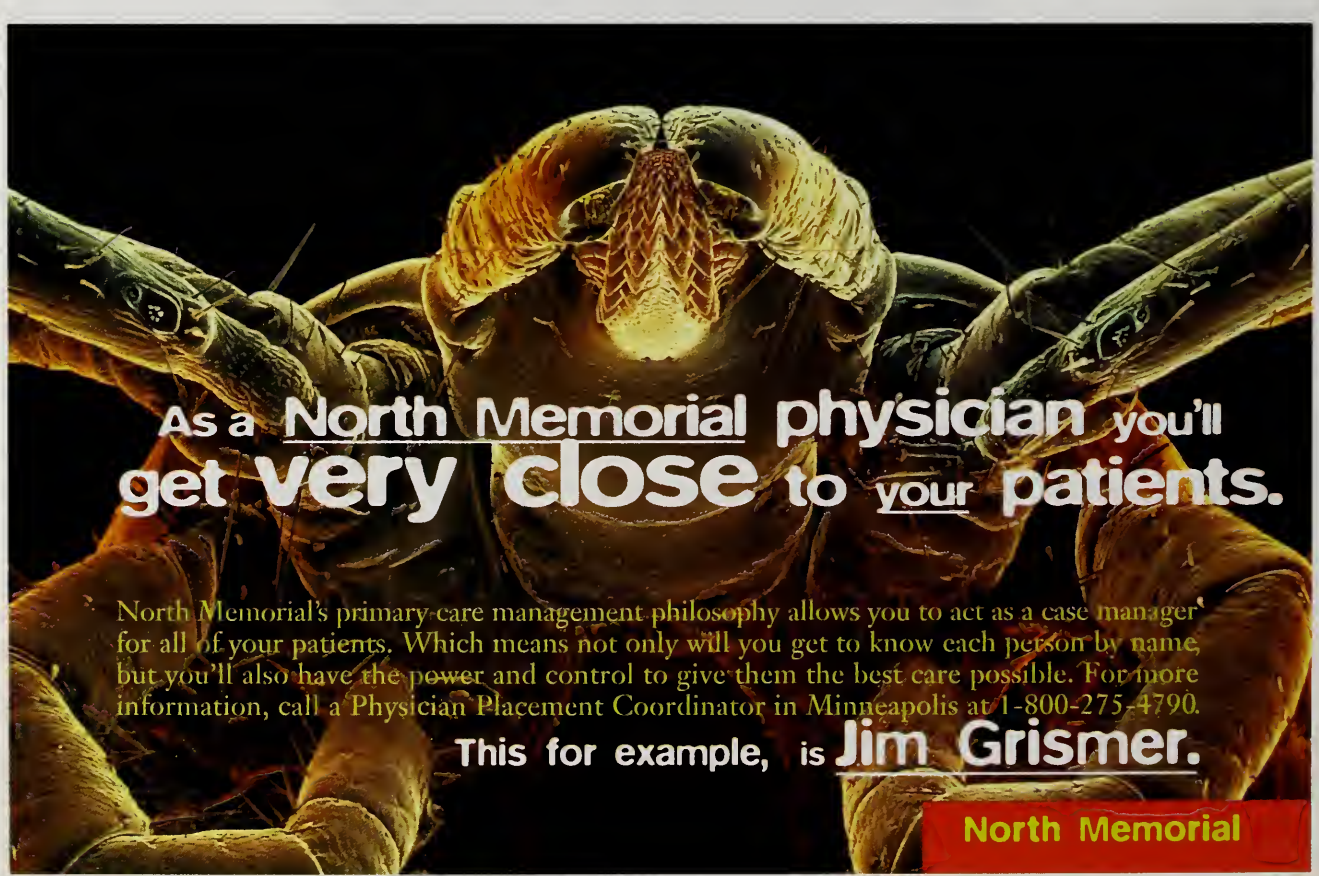
Holtan is not optimistic that preventive medicine will become a priority any time soon, however. "If the payoff for prevention is 10 years from now, why would a prepaid plan want to put a lot of resources into achieving that goal?" he asks. "The people who are currently insured by them might switch to another health plan in two years. With a lot of patients switching from plan to plan, the payoff is too long to make it worth putting the resources into it."

Holtan admits this is a harsh observation. But, as a bureaucrat himself, he is aware of the political and economic realities that affect choices in the business of health care. "I don't think anyone actually sits down and makes such cold-hearted judgments, but somehow priorities emerge," he says.

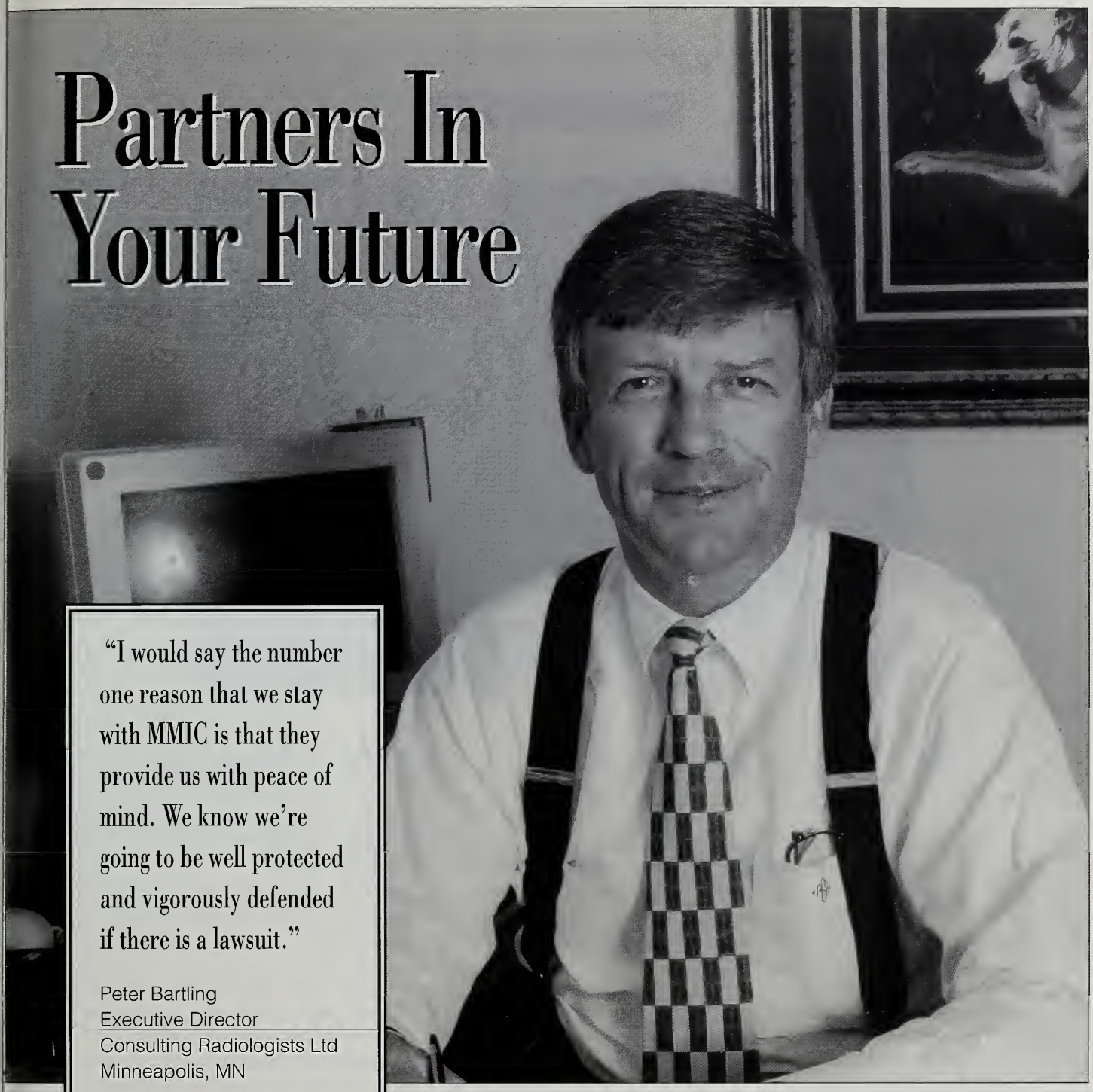
For now, Holtan's priority is achieving successful outcomes in the worlds of clinical medicine and public health administration. By working in both disciplines, he fosters cooperation and shatters stereotypes along the way. MM

Jeremiah Christopher Whitten is a Minneapolis-based media relations consultant who specializes in health care issues and high technology.

University of Maryland



Partners In Your Future



"I would say the number one reason that we stay with MMIC is that they provide us with peace of mind. We know we're going to be well protected and vigorously defended if there is a lawsuit."

Peter Bartling
Executive Director
Consulting Radiologists Ltd
Minneapolis, MN

In today's changing medical environment, physicians need to view their professional liability insurer as an important partner in their future. And what better partner can a physician have than a physician-owned and controlled liability insurer such as Midwest Medical Insurance Company. A company that understands a physician's desire to practice the art of medicine.

As your partner, MMIC is here to assist you in your new working relationships and to develop products and programs which improve patient care and lower liability exposures.

MMIC is here for the long term. We bring to the partnership a financial strength of over $251 million in assets and a total equity of over $104 million. Our rating from A.M. Best is A (EXCELLENT).

For a competitive quotation and other information on services offered by MMIC, please call us at 1-800-328-5532.

MMIC

MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S. Minneapolis, MN 55435-1891



PHOTOGRAPH BY AP/WIDE WORLD PHOTOS

Waging a Noble War against a River

by Kenneth R. Carter, M.D., and Darrell L. Carter, M.D.

"And on the eighth day God created sandbags and hot dishes."

THIS YEAR'S FLOODING in the Minnesota and Red River valleys followed one of the hardest winters of modern times. Frequent blizzards and snow-blocked roads condemned many rural communities to prolonged periods of isolation. Many weeks, schools were closed more than they were open. Emergency teams performed heroics to deliver care to critically ill patients. As the seemingly never-ending winter wore on into the spring, huge piles of snow remained, undiminished by winter thaws or spring snowmelt. In mid-March, as officials predicted that the flood of 1997 could equal the worst on record, longtime residents shared tales of terrible inundations of the past.

University of Maryland

Granite Falls is located in a picturesque granite outcropping along the Minnesota River. The river drains a large section of west-central Minnesota and eastern South Dakota. It snakes through Granite Falls in an S shape, with an electric power dam in the central part. Businesses and homes are built along both sides of the river, but most are well out of reach of normal floodwaters.

Granite Falls' mayor, city manager, and city council took the flood threat very seriously, and with the help of the Army Corps of Engineers planned for high water even before the snow melted. As soon as the weather allowed, in late March, crews reinforced old dikes and built a new dike 15 to 18 feet above the river, to a level that would have protected against the worst flood in the town's history. A few armchair engineers poked fun at this measure, seeing it as unnecessary and ridiculous.

Granite Falls community members joined forces to save their city from the rushing waters of the Minnesota River.

From April 1 through 3, the Minnesota River started to rise in earnest. By April 4 city officials saw that their preparations were not going to suffice. Granite Falls residents would have to join forces to wage war against the mighty river.

City leaders assumed roles much like military officers to coordinate the defense. Thousands of volunteers—most of whom had never experienced a disaster—needed to be organized into functional units, trained in flood fighting, transported to different locations, rotated between jobs, and fed.

The weather on Friday, April 4, was pleasant as most people in town joined the flood-fighting activities. As we worked through Friday night, the weather turned foggy and colder. The rush of water sounded like a train rumbling through town, and the ground trembled from the force of some 350,000 gallons of water per second cascading over the dam. The river churned into froth as it sped along at 35 to 40 miles per hour. (Normally, it flows at two to three miles per hour. Engineers calculated that the amount of water flowing through Granite Falls in just 24 hours would have filled Lake Mille Lacs.) The arrival of the National Guard added to the eerie atmosphere. Military trucks blocked the streets, and we had to have passes to move around town.

The cool fog gave way to a cold rain that continued through Saturday, April 5. Snow followed on Sunday, along with fierce northwest winds. Blizzard conditions and wind chills near zero degrees made it impossible for people to get to Granite Falls to relieve the tired workers.

The Deluge Diner

Countless examples of indefatigable work make up the Granite Falls flood story. One of our patients with severe pulmonary hypertension drove his pickup for 52 hours straight, hauling sandbags from a filling point to the dikes. He took a break only when his basement started to fill with sewage backup.

Volunteers young and old worked around the clock to keep up with the rising waters. The National Guard, the Red Cross, and the Salvation Army assisted in areas where local resources were lacking. The news media told the world of our plight, prompting busloads and carloads of people to drive long distances to help. Others sent food, drinking water, and supplies.

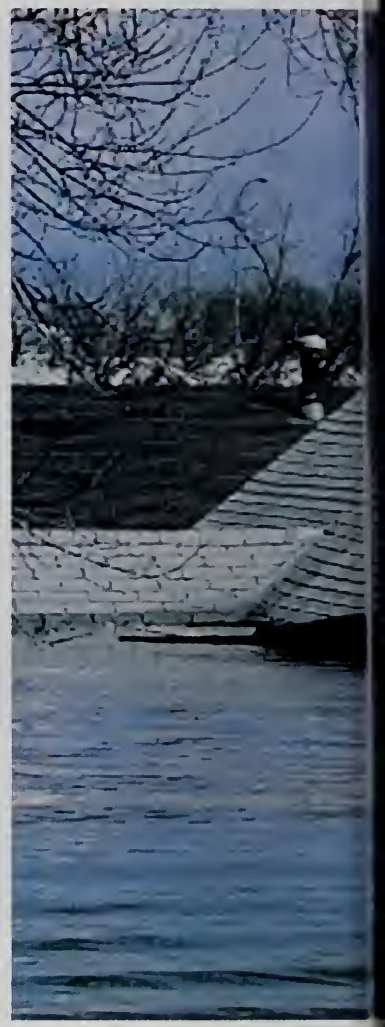
Several women in the community organized the churches to feed and warm the weary workers. The "Deluge Diner" was born as floodwaters began to threaten the American Legion Hall, site of the initial food canteen. The parish hall of St. Andrews Catholic Church served as the new food center. Congregations from within and outside Granite Falls responded to the need to support the army of volunteers who filled, moved, and placed 600,000 sandbags in just over 72 hours. Whenever a call came in for food, a hot dish or cauldron of chili appeared as if from heaven. The Deluge Diner stayed open for almost a month,* serving as a refuge for many home and business owners and reinforcing the sense of community as people ate meals together.

No Serious Injuries

From a medical standpoint, we ended up someplace between fortunate and blessed. Although thousands of people helped fight the flood, and one slip of a foot could have plunged a worker into the cold, raging water, we had no deaths or serious injuries. Many people suffered overuse injuries from performing jobs they were neither trained nor physically prepared

NOBLE WAR continued on page 57

Floodwaters Bring Docs to the Front



Amid the chaos caused by the 1997 floods, Thomas Cariveau, M.D., set up a MASH-like clinic to provide care to the devastated community of East Grand Forks.

By Karen M. Stensrud

"War zone."

That's how Thomas Cariveau, M.D., describes the low-lying East Grand Forks neighborhood he is standing in, one month after the Red River devastated East Grand Forks, Minnesota, and its sister city of Grand Forks, North Dakota. Before the water receded, Cariveau says, only the chimneys of the homes along this street were visible. Heaps of debris—mud-caked carpet, furniture, toys—line the curbs. Directly behind Cariveau, an overturned storage shed rests at the edge of the street, where the river deposited it. Cariveau points to a small yellow house down the block.

"We lived there until I was 7," he says.

It won't be long before that house, and those around it, are memories. This neighborhood sustained such severe damage in the flood, it's likely the city will buy out and raze the homes rather than rebuild them.

Cariveau, a family physician at the University of North Dakota Family Practice Center in Grand Forks, is familiar with his hometown of East Grand Forks—its neighborhoods, streets, and businesses. He also knows the medical needs of its people. Recruited straight out of residency at Mayo Clinic, Cariveau practiced at an East Grand

University of Maryland



PHOTOGRAPH ©1997 STAR TRIBUNE/MINNEAPOLIS-ST. PAUL

Forks satellite clinic for five years before the clinic was closed in 1992, leaving East Grand Forks residents without a clinic of their own. Today, they are accustomed to driving across the river for medical care.

When the Red River crested at record levels in April, Cariveau was back in his hometown—ready to help residents in danger of being stranded without medical care.

Preparing for the Worst

East Grand Forks and Grand Forks residents thought they were ready for the flood they'd watched wreak havoc in Wahpeton-Breckenridge, Fargo-Moorhead, and other communities along the Red River. But as crest predictions rose, officials realized that other preparations needed to be made, and quickly.

East Grand Forks Mayor Lynn Stauss phoned Cariveau as the river continued to rise and the magnitude of the crisis grew.

"What are we going to do about medical coverage for East Grand Forks?" Stauss asked the physician.

"We were very concerned there would be no medical personnel [on the Minnesota side] at all," Stauss recalls. "There's no clinic in East Grand Forks." If highways leading out of town were cut off by floodwaters, he feared, "we had the potential for the whole city to become an island, with no medical care available."

Stauss and Cariveau decided to establish a temporary clinic in East Grand Forks. It hadn't been done before, but an obvious site was Northwest Technical College, where many students train to become medical and laboratory technicians, medical aides, or medical secretaries.

"Part of their facility includes training areas set up like a clinic or hospital," says Cariveau.

With the flood situation looking increasingly grave, Cariveau's team of residents and other medical professionals rolled into action to set up the East Grand Forks site. The emergency department at Grand Forks'



PHOTOGRAPH BY DAVID HETLAND

"My fear was that there would be a disaster on top of the disaster—some major trauma or loss of life."

–Thomas Cariveau, M.D.

United Hospital provided equipment. Hospital beds and wall oxygen units were already in place at the technical college, and the addition of a defibrillator and crash cart helped complete preparations for emergency, trauma, and cardiac patients. Essentially, the place was a triage center, equipped like a MASH unit.

"We were anticipating mainly potential MI problems," says Cariveau. "People were out working to save their homes, sandbagging, hauling things up from basements, and maybe they were doing more than they should, overexerting. And we were worried about trauma—fractures, falls, bruises."

The team set a week-long schedule—highly optimistic, as it turned out—to staff the clinic. By the time the clinic opened, on Friday, April 18—with a physician and residents, nurses, emergency medical personnel, and a receptionist—the need for care was urgent. Inching its way to a record crest, the Red was at nearly 54 feet, more than 30 feet above flood stage. Temporary dikes were beginning to breach.

The Last Bridge Closes

At the immediately busy clinic site, people working in dirty water and with contaminated debris received tetanus shots. Parents brought their children in to be treated for febrile illnesses.

"They didn't want to take their children across the bridge," explains Cariveau, "because the water was so high they didn't know if they'd get back."

There were no charges assessed or official records kept for patients at the East Grand Forks site—just notes that eventually would be forwarded to the patients' regular physicians.

Amid what Cariveau terms "organized chaos"—the traffic of heavy equipment and carloads of people beginning to heed pleas for evacuation—a commute from East Grand Forks to the medical park on the west side of Grand Forks would have taken nearly an hour.

"I've covered East Grand Forks before," says Cariveau. "But this was really serious. At the time, we were looking at the Kennedy Bridge going down."

Kennedy was the last of three bridges connecting East Grand Forks and Grand Forks to remain open. In the wee hours of Saturday morning, with water covering the bridge entrances on each side, the Kennedy was closed. Cariveau, who was evacuating his parents to his own home west of Grand Forks, was notified of the closing in time to make it back across the river to the clinic.

"My family was prepared," he says. "My wife knew I'd be committed to the clinic and that we'd be separated by the river."

Saturday was the real day of crisis at the East Grand Forks clinic. The 170 patients at Grand Forks' United Hospital were evacuated when the river reached critical levels. With no bridge available, the hospital's Minnesota patients were lifted out by helicopter. Cariveau's clinic helped receive and triage those patients; ambulances met the helicopters and transported patients to hospitals in Bemidji, Crookston, and Thief River Falls. By about 9 p.m., just before dark, the operation was complete.

Evacuation Staging Center

Meanwhile, mandatory evacuation of all other East Grand Forks and Grand Forks residents—more than

University of Maryland

50,000 people—had begun. At the technical college, the East Grand Forks staging point, evacuees checked in, then were bused to Crookston, where they were registered and assigned to one of 13 temporary shelters.

"By that time, the National Guard was all over the place," says Cariveau. "People who'd waited to evacuate had to be moved in five-ton trucks or by helicopter. We were seeing guardspeople who got hurt. Playing a leadership role was part of our function—organizing spontaneously what needed to be done. We were anticipating medical care, but we also just had to keep checking with the technical college staff, knowing what was available for certain situations."

It was during the evacuations that Cariveau experienced his only pangs of fear, he says—not for himself, but for others.

"We knew there were some tough situations, with dikes breaking, fires starting, evacuating people in helicopters over all that water," he says. "My fear was there would be a disaster on top of the disaster—some major trauma or loss of life. Would we be able to deal with that? You can deal with these things case by case, but if you have a hundred people dumped on you... ."

Instead, Cariveau and the residents who assisted him continued to see pulmonary problems, exacerbation of asthma, bruises, and sprained ankles. One elderly woman suffered a fractured wrist and nose during a fall. A handful of patients came in with overuse syndrome or tendinitis. "They'd put it off because they were sandbagging, then stopped to take care of it on their way out of town," Cariveau recalls.

Often the action at the clinic reminded Cariveau of a military operation. He worked with the sheriff's department to establish "emergency hold" orders, given as a prescription signed by Cariveau, so mentally ill patients could be physically removed from their homes. Home-care personnel worked with the clinic staff to coordinate evacuation of elderly or post-hospital patients. Evacuees from one East Grand Forks nursing home were also brought to the technical college, where they were temporarily housed in the gym.

"Our No. 1 concern was safety—to make sure our residents were safe, to make sure our patients were safe, rather than wait until things were so far under that they were swimming out of there," Cariveau says.

With water rushing down city streets, the clinic staff's plans changed by the hour. By late Saturday, it was clear that even the clinic site and evacuation staging center would have to be closed.

"About 10:30, we pulled out," Cariveau says. "All the roads to the Tech were surrounded by water; most people had been evacuated by then, and the hospital was empty."

Refugee Physicians

But the physician's work wasn't over.

"Our next step was to go to Crookston, to take care of our people there," says Cariveau.

For the next month, Crookston was home to Cariveau and other Grand Forks physicians. Crookston saw an influx of some 8,000 flood refugees—

MMA Flood Relief Fund Helps Water-Damaged Clinic

Much to everyone's relief, United Hospital in Grand Forks was not damaged by the flood that forced evacuation of 170 patients there. The clinic in Ada, Minnesota, was not so lucky, however. Bridges Medical Center, a city-owned facility in Ada, 30 miles northeast of Fargo-Moorhead, suffered devastating water damage. The Federal Emergency Management Agency will provide money to repair, but not replace, the center, which includes a hospital, clinic, and nursing home. Kyle Rasmussen, clinic manager, says he doubts it will be possible to repair the severely damaged buildings and estimates that an additional $3.5 million will be needed to rebuild. Currently, physicians and patients are making do with a Winnebago trailer as an exam room.

The MMA has set up a special fund to help the Bridges Medical Center, which appears to be the only clinic in Minnesota that sustained structural damage in the floods. In addition, the MMA has collected donated supplies that were distributed by the Salvation Army.

The MMA Flood Relief Fund was established through the Minnesota Physicians Foundation, a charitable foundation affiliated with the MMA. Tax-deductible contributions may be sent to MMA Flood Relief Fund, Minnesota Physicians Foundation, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413, Attn: Kimberly Halva. If you would like to offer help to physicians in the flood-damaged area, the MMA can connect you with them. Please call the MMA, 612/378-1875 or 800/DIAL-MMA, or visit the Web site at www.mnmed.org.



PHOTOGRAPH ©1997 STAR TRIBUNE/MINNEAPOLIS-ST. PAUL

"We were very concerned there would be no medical personnel on the Minnesota side at all. There's no clinic in East Grand Forks."

–Mayor Lynn Stauss

4,000 of whom remained for the next two to four weeks, stretching the medical resources of the community of 8,500 people.

With news of the evacuation of Grand Forks and East Grand Forks, Crookston's medical personnel immediately prepared for refugee care.

Physicians Bruce Ring, Rolf Hanson, and Ted Olson from Northwestern Clinic in Crookston got together to organize a response to the crisis. "We started with a 7 a.m. meeting at the hospital," says Bruce Ring, M.D., an internal medicine physician. "We held those every morning for that first week or 10 days."

With representation from Crookston's hospital and clinics, as well as displaced physicians from Grand Forks and East Grand Forks, a hurriedly formed team discussed potential problems, including infectious diseases, trauma or critical care cases, and staffing at the hospital, clinics, and shelters.

Arrangements were quickly made to grant emergency temporary licensure to North Dakota physicians, and the hospital provided pagers for displaced doctors. Within two days, a physician or resident and nurses were staffing almost all 13 shelters in Crookston. Their first task was to take inventory of needed prescription medications—many evacuees had left without them—and provide patients with a one-month supply. Outbreaks of diarrhea were a concern, but were prevented, Ring says, because staff "did an excellent job of keeping healthy food going in and getting people dispersed from the shelters within five to seven days."

The sheer volume of patients presented a challenge to the medical community. The Crookston hospital, which typically has 10 to 15 beds in use, received a shipment of eight beds originally intended for United Hospital in Grand Forks. The beds were filled within 48 hours, and more than 30 professionals, all flood refugees, were hired temporarily to help handle the patient load. With many roads flooded, arrangements were made for helicopter transport of trauma or critical care patients.

Northwestern Clinic expanded its hours, remaining open from 8 a.m. to 8 p.m. daily. Satellite clinics in Red Lake Falls, Erskine, and Fertile, normally open a few days a week, were staffed full time to accommodate refugees housed in the Lakes area. Crookston physicians and staff, themselves concerned with potential flooding in low-lying areas along the Red Lake River, worked side by side with flood refugees.

"At various times, I shared my office with six other physicians," says Ring. "I really give them credit. Many of them couldn't even get to their homes to see what kind of damage there had been. Some physicians came out with not much more than the clothes on their backs—but they were thinking about how to care for patients, how to organize, how we would take care of trauma or critical care."

Erik Kanten, M.D., a family practictioner at Northwestern Clinic, made sure that evacuee centers were covered for emergencies and ensured that the centers followed public health standards.

Specialists among the refugee physicians provided basic services at the hospital and clinics, including obstetrics/gynecology, pediatrics, oncology, urology,

University of Maryland

and ENT. "We did a lot of chemotherapy in the clinic during that time," Ring comments.

Refugees in Crookston focused first on immediate needs, but that changed as they returned to their routines. "Late in the second week, people started to remember about their lives," says Cariveau. "We got calls from OB patients wondering where they could be seen and where they could deliver, and postsurgical patients who needed to be seen, or people who'd had surgery scheduled and now wondered what to do."

When Cariveau's Grand Forks practice did reopen a month later—along with United Hospital—the psychological backlash of the disaster also became apparent.

"People have had enough time," Cariveau says. "They first concentrate on their property, homes, cleanup, and damage assessment, dealing with organizations like FEMA (the Federal Emergency Management Agency) or their insurance company. Now they start to feel the frustration. Their lives are in limbo. They're stressed, and they act just like they have posttraumatic stress syndrome—like a victim: 'I've been used, I've been beaten, what do I do?' They come in with nightmares, anxiety, depression."

Being in Practice Gets You Ready

Thanks to a combination of planned action and quick response, the temporary clinic and facilities in outlying communities met the goal of providing medical care and safety for flood victims.

"We have contingency plans in place for disasters," Cariveau comments somewhat ruefully, "but I don't remember any flood drills."

Little in his medical school training could have prepared Cariveau for the needs that arose during what's been called the flood of five centuries.

"But being in practice gets you ready," he says. "It's knowing the people and their problems. They have confidence in you, and when they see you, it gives them a lift. They're at the triage center, not knowing what's happening, but they're willing to go with the program because you're there."

The fact that no one was killed in East Grand Forks or Grand Forks during the flood is perhaps the greatest wonder to Cariveau. Preparation and a levelheaded response, he believes, prevented greater tragedy.

"I think people really listened to the city and to the Guard when they told them it was time to evacuate, and that's how we avoided loss of life," he says.

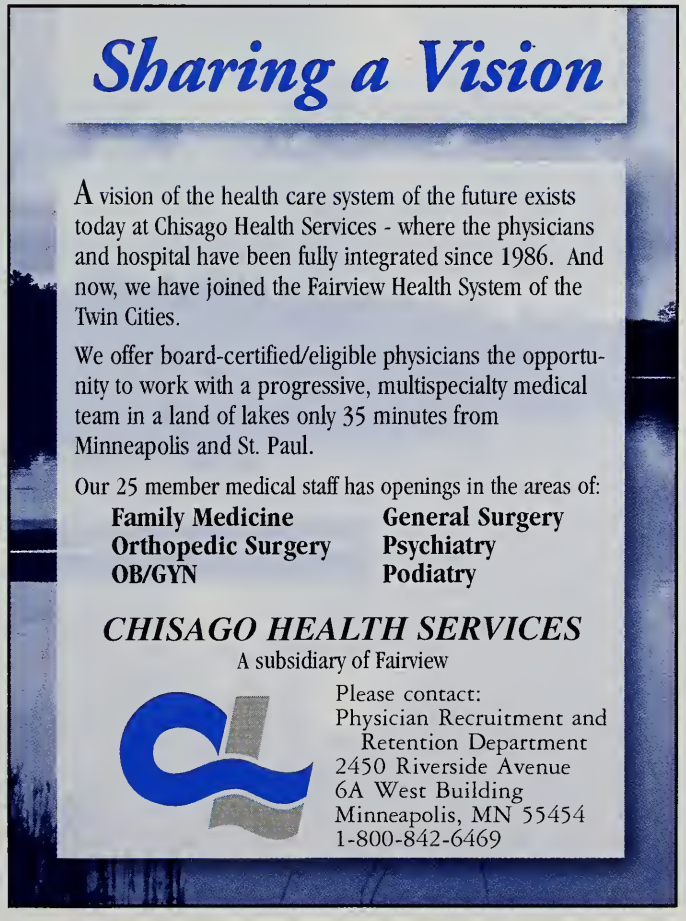
Afterward, the physician heard many residents second-guessing the city, the National Guard, and themselves, wondering if they should have stayed in their homes. It's a scenario he doesn't like to consider.

"You multiply that out and have several thousand people in trouble, and how could you get medical attention to them when the only way around is by huge trucks or by boat?" Cariveau asks. "We could have had some very significant tragedies."

He pauses, remembering. "The only real threat we had was when two guys were in a boat in downtown Grand Forks during the fire, and it overturned. We thought we might have trauma patients."

Cariveau chuckles: "Turned out the police rescued them—straight to jail." MM

Karen Stensrud is a writer and marketing consultant with more than 10 years' experience in health care and other areas. She is a former writer for Dakota Heartland Health System in Fargo, North Dakota.



A Partnership *for* Public Health



ILLUSTRATION BY JOHN BERRY

Medicine and public health team up to combat modern ills.

Minneapolis neonatologist Richard Lussky, M.D., has no trouble recognizing the signs of fetal alcohol syndrome in a newborn. Unfortu-

University of Minnesota Library

nately, Lussky can't cure babies of FAS; prevention is the only cure. "All women have to do is not drink during pregnancy," says Lussky, who was instrumental in getting a new law passed that will provide $1.25 million in funding over two years to combat FAS in Minnesota. The initiative will focus on prevention and early identification of pregnant women who are abusing alcohol and on screening children affected by FAS and the related fetal alcohol effects.

Lussky's venture into the public policy arena reflects a growing belief among physicians that they should be more active in promoting public health.

"The role of physicians is beyond one-on-one care for patients. They need to be in policy and program development," says Mary Braddock, M.D., M.P.H., medical director of Community Health and Preventive Medicine at Children's Health Care.

Increasingly, physicians are discovering that they alone cannot combat many of the medical ills they see today. Like FAS, these problems often are tied to social issues that demand community intervention. Abuse of alcohol, tobacco, and other drugs; domestic violence; and diseases like AIDS—problems that won't be eliminated in the doctor's office—are leading physicians in clinical practice to turn to their public health colleagues for help.

While physicians encounter these patient concerns on a case-by-case basis, public health professionals see them as issues of community significance. Such problems can best be addressed with the tools and principles of public health, together with the clinical approaches available in the doctor's office, say physicians who practice in both worlds.

Medicine and public health must collaborate to keep up with modern-day disease and prevent backsliding on older diseases currently under control, says Philip Lee, M.D., former assistant health secretary for the U.S. Department of Health and Human Services. Lee called for a closer link between the two disciplines at a June 13 conference co-sponsored by the Minnesota Medical Association on the relationship of medicine and public health in Minnesota.

Lessons from the Past

Cooperation between medical clinicians and public health practitioners is not a new concept. Back when infectious diseases, unsafe water, and unsanitary conditions were primary causes of death and disability, medicine and public health worked closely together to eradicate disease. In the mid- and late 1800s, physicians promoted such public health measures as clean water, hygiene education, quarantine, and immunization. But by the beginning of the 20th century, the emergence of advanced technology, antibiotics, and other drugs to alleviate disease fostered "miracle-cure" thinking—people began to worry less about prevention because medicine had discovered cures.

But reduced vigilance can lead to serious public health problems. With society's guard lowered against tuberculosis, for example, drug-resistant TB developed, says Lee, who is currently senior adviser to the dean of the School of Medicine, University of California–San Francisco. He calls antibiotic-resistant infections "a bomb about to go off."

The recent Twin Cities conference, sponsored by the Minnesota Medical Association, the Minnesota Public Health Association, and the Center for Population Health, was one of several recent initiatives across the country examining ways clinical medicine and public health can unite to achieve community health goals (see sidebar, pages 22-23).

Public health practitioners and medical clinicians came together at the conference to discuss ways to engage the community, educate the public, collaborate on research, devise a shared view of health and illness, work together to provide health care, and develop health care assessment measures.

"Until now in Minnesota, public health and medicine have operated in silos, interacting intermittently and rarely, to the detriment of both professions," says Braddock. "I think both disciplines are weaker if they don't work together. Neither has enough skills and resources to solve broad health problems by itself."

Public Health and Medicine Confront 'Lifestyle' Diseases

The public health goals discussed at the conference share a common thread: most address diseases related to human behavior. Today, lifestyle choices are compromising health and endangering life, says Carolyn McKay, M.D., former head of the Minneapolis Health Department who now divides her time between practices in Ithaca, New York, and at St. Paul-Ramsey Medical Center.

"Public health's job is to recognize problems, investigate, and lay out possibilities for change," says McKay. Car crashes once used to be considered inevitable, but "if you change the design of roads and cars, reduce alcohol access, license drivers, and get rid of the bad drivers, you can make changes. These are controllable factors."

continued

In the past, the role of medicine, she adds, has been to relieve suffering, often when the patient is severely ill or dying. Now physicians are seeing the need do more preventing—watching cholesterol, reducing blood pressure, advising patients to stop smoking or lose weight. Physicians also have worked with tobacco-control advocates on legislation to reduce access to tobacco products for teens and children and to increase taxes that deter young smokers.

Working as a Team

Alcohol abuse is another example of a social issue medicine and public health can confront as a team. Studies indicate that 15 percent to 40 percent of general medical admissions are related to addictive disorders, including alcoholism, according to Macaran Baird, M.D., a family physician and medical director for primary care at HealthPartners and a panelist at the conference. But alcohol-related problems can't be solved during a physician's brief time with the patient; they must be addressed by the entire community.

"Physicians and other practitioners are gaining skills—though it's still difficult—in assessing patients and discussing steps they can take to reduce alcohol abuse," says Baird. "But alcohol-related problems aren't decreasing like other conditions, say measles or dental cavities, despite the new social landscape that is generally less accepting of drunkenness and more tolerant of moderate drinking or abstention, and despite the increase in self-help programs, education, referral sources, and treatment centers.

"A good deal of that is related to public policy and social messages, not the individual efforts of physicians," says Baird. "It's humbling for physicians to know they don't have a fix that's technical or medical."

Speaking on the same panel at the conference, Donna Anderson, M.P.H., public health director for the Dakota County Public Health Department, described an inno-

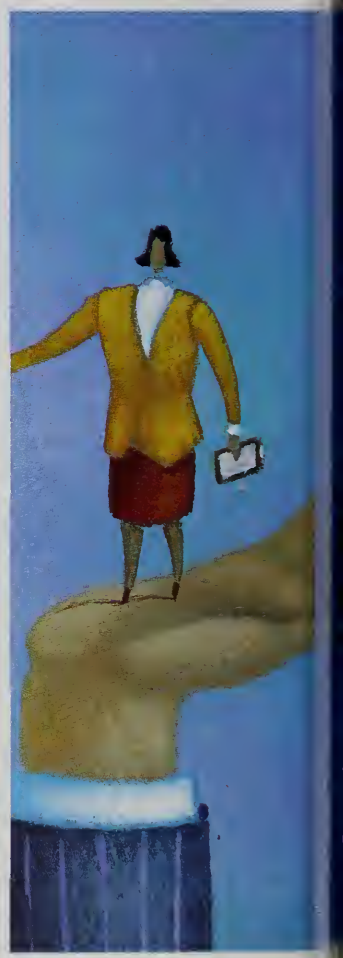


The Managed Care Connection

The rise of managed care creates opportunities to narrow the gap between medicine and public health. Among the give-and-take factors:

- Public health disease prevention and health promotion strategies can reduce health care costs in the private sector.
- Managed care's measurement of outcomes and quality enhances community health assessment efforts and re-emphasizes the importance of traditional public health functions.
- Managed care provides a continuum of health care services emphasizing primary care and prevention.
- Proliferation of provider groups and networks allows public health to more easily identify partners for community-based disease prevention and health promotion campaigns.

Reprinted with permission from American Medical News *1997;40(16):3,19-20. ©1997 American Medical Association.*



University of Maryland

vative plan to strengthen alcohol-related preventive services in Dakota County. A work group of the Dakota Partnership for Healthy Communities has brought together representatives from every health care organization in the county, including the Dakota County Public Health Department, hospitals, mental health providers, and managed care organizations, to look at how they can collaboratively address the disturbing realities of alcohol abuse.

"In the past, these groups had the same goals for prevention but worked separately," says Gina Adasiewicz, M.P.H., a community health educator with the Dakota County Public Health Department. "Working together strengthens our bond and helps meet the needs of people in our community by bringing together resources, such as people and knowledge."

The project is in the assessment phase now, surveying the capabilities and needs of member organizations, and will work on an action plan next. Working together has helped the groups discover—with some relief—that they are all speaking the same language and seeking the same outcomes, says Adasiewicz.

Another public health measure that would bring together physicians and public health professionals is the establishment of a statewide immunization registry, a proposal considered but not passed during Minnesota's 1997 legislative session. "This is one of the best things that could be done to foster cooperation [between medicine and public health]," says Sally Trippel, M.D., M.P.H., a Mayo Clinic internist and chair of the MMA's Public Health Committee. "It was tabled because of privacy concerns, which is harming the people that could benefit from it."

Trippel also sees medical training as a place where public health principles could be put to good use. "The hours devoted to public health training are pretty minimal," she says. "Practitioners should know the importance of disease reporting and how to manage diseases

States Take the Initiative

This spring Minnesota became a laboratory for exploring potential collaboration between clinical medicine and public health when the Minnesota Medical Association and the Minnesota Public Health Association convened the conference "Medicine and Public Health in Minnesota: Defining Common Goals and Strengthening Relationships."

The June 13 conference was funded by a grant from the Robert Wood Johnson Foundation and held as part of the Medicine–Public Health Initiative launched in 1996 by the American Medical Association (AMA) and the American Public Health Association (APHA) to strengthen the ties between the two health sectors.

As part of that effort, the AMA House of Delegates last summer endorsed a set of recommendations by the National Congress on Medicine/Public Health hosted by the AMA and APHA. The congress recommended that medicine and public health:

- Work together to persuade health care educators, providers, and purchasers to assess and address the health needs of entire communities;
- Allow for more cross-training of medical and public health students and residents;
- Develop a joint research agenda;
- Integrate more health promotion and disease prevention into clinical and community settings; and
- Jointly develop health care assessment measures to enhance quality and ensure accountability.

Also in line with the national initiative, the New York Academy of Medicine hosted a symposium in April to examine how changes in the health care environment are forging a closer bond between medicine and public health. The symposium was based on the work of a multidisciplinary panel of practitioners and scholars, a series of focus groups, and a nationwide survey describing medicine and public health interactions. A monograph of the panel's work should be available next November.

If you would like to be added to the mailing list to receive a copy of the monograph, contact:
Mike Palica
New York Academy of Medicine
Division of Public Health
1216 Fifth Avenue
New York, NY 10029
fax: 212/426-6796
E-mail: mpalica@nyam.org
Web address: www.nyam.org/pubhealth/mail.html

Allina knows what's important to our physicians. That's why we've created a progressive, not for profit health organization that values your time and talent.

"...what Allina did for our careers was great; what they did for our families was amazing."

We offer desirable call schedules and excellent physician support, allowing you to do the work you love, without abandoning your loved ones. Allina is currently seeking physicians in the following categories: **Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, Locum Tenens, and Dermatology.**

Our Minnesota/Wisconsin locations have numerous metro and rural opportunities—along with our rewarding career structure, excellent compensation package, and family relocation assistance.

If you love your work, you'll love Allina.

Call our Physicians Services Group
612-992-3093 or 1-800-248-4921
Fax 1-612-992-3669
Allina Health System . Route 80775
5601 Smetana Drive . Minnetonka, MN 55343

ALLINA
HEALTH SYSTEM

that have implications for others in the community–such as communicable diseases like STDs and tuberculosis." A doctor who is trained to treat one patient at a time may not think to ask someone with chlamydia about his or her partner.

Of course, a practicing physician doesn't need an M.P.H. to apply a dose of prevention.

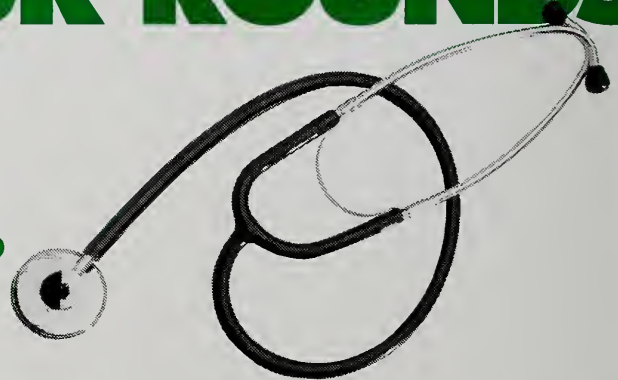
"All physicians could stand to increase the amount of preventive care they do," says Braddock of Children's Health Care. "It's important to have more patient time to talk about domestic violence, alcohol use, health education, and issues that affect families."

More and more, physicians are finding these issues cross social, medical, and public health boundaries. MM

Lisa Taylor Lake, former communications coordinator for the Community Prevention Coalition of the Hennepin County Community Health Department, contributed to this article as a free-lance communications consultant. She is currently working as a public information officer for the Minnesota Department of Health.

www.startribune.com/workavenue

MAKE YOUR ROUNDS ON NEW GROUNDS.





Put your resume on WorkAvenue.com. It's a free, Star Tribune Internet Web site that automatically matches job openings with resumes from people in the health field and other industries. It's free, easy and confidential.* So go to the site. Because we make finding a new job painless.

If you don't have Internet access, send your resume to WorkAvenue.com, Star Tribune, P.O. Box 1617, Mpls., MN 55440-1617. It'll be electronically scanned and placed in the Workavenue.com database. For best results, call 612-673-9012 first.

*The confidentiality feature is only available when you enter your resume on-line.

370073/6/97

Star Tribune Online MINNEAPOLIS/ST. PAUL

www.startribune.com/workavenue

Star Tribune
It's where you live.

University of Maryland

Public Health Response to the 1997 Minnesota Flood

Lessons Learned

Helping flood-ravaged communities provide essential services, the Minnesota Department of Health learned important lessons for the future.

Agnes T. Leitheiser, R.N., M.P.H., Mary Rippke, R.N., M.S.,
Mary Sheehan, R.N., M.P.H., Jack Korlath, M.P.H., and Buddy Ferguson

Editor's Note: The flood of 1997 tested the ability of many organizations and citizens to respond to a crisis. While we will never know about most private heroes, the Minnesota Department of Health shares an overview of their flood activities in this article. The duties they describe are reminiscent of a time when public health's core value was the control and prevention of infectious disease. All of us hope that the lessons learned will not be needed in a disaster this extensive for many years to come.

–Barbara P. Yawn, M.D., M.Sc.,
Series Editor

Many Minnesotans lost their homes, their jobs, and even their communities to the spring floods of 1997. The Greater Minneapolis Area Chapter of the American Red Cross estimates that the flooding affected 23,263 families in the Red River Valley and the Minnesota River Valley.[1] The estimated financial impact is over $1 billion in Minnesota alone. Minnesota's official flood emergency began March 21, and full recovery is expected to take about two years.[2]

A flood emergency can disrupt essential environmental services, such as the provision of safe drinking water and disposal of sewage and contaminated materials. Flooding also requires an emergency public health response to prevent communicable diseases, provide safe food at mass feeding sites, and otherwise protect affected communities. As floodwaters recede, needed services shift to those associated with cleanup and rebuilding. During the 1997 floods, the Minnesota Department of Health (MDH) worked with local public health agencies to coordinate these essential public health services in areas that were affected by flooding or that housed persons displaced by the flooding. The challenge of the floods provided an opportunity to learn more about public health roles and responsibilities in a crisis and to prepare for the future.

Safe Drinking Water

A critical foundation of public health is plentiful, safe drinking water. Contamination of community water systems and private wells with floodwater is a significant concern. Some community water systems were contaminated despite the heroic efforts of water-supply operators. State health officials tested water quality and worked with local staff to ensure that these systems were quickly restored to normal operation and that safe drinking water standards were met. In some communities, staff went door to door flushing systems and testing tap water.

In the event of possible bacterial contamination, residents are advised to boil water for five minutes before using it for drinking or cooking. This may not be possible in areas where electrical service is down. Temporary water supplies trucked into these communities require monitoring for chlorine residual and bacteriological quality, usually daily. At the first sign of contamination, the water tanks must be taken out of service to prevent disease transmission.

Private wells are assumed contaminated if the well casing has been submerged or the floodwater has come within 50 feet of the well. All wells in flooded areas should be tested before resuming normal use. Well owners with positive coliform test results were instructed on disinfection and testing. Federal public health staff went door to door in rural areas to help identify wells that required disinfection or testing. Of the 1,000 wells tested, 30% were positive for fecal coliform.

Contact with Floodwater

Simple skin contact with floodwater does not carry any significant risk of infectious disease.[3] The primary concern is potential enteric exposure when people eat, drink, or smoke. Frequent, thorough hand-washing is recommended for residents and volunteers working in floodwaters or with flood-contaminated material to prevent hand-to-mouth exposure to disease organisms.

Historically, microbiologic testing of floodwaters has revealed only low levels of contamination, primarily because of the dilution that takes place during flooding. However, the accumulation of floodwater or sewage in basements requires special precautions.

continued

Immunizations

No epidemiologic evidence indicates that flooding involves any increased risk of tetanus. Therefore, the MDH recommends only 1) adherence to standard recommendations that call for a diphtheria-tetanus booster once every 10 years, and 2) if an individual sustains a puncture wound, consultation with a physician to determine the need for a tetanus booster. Other public and private organizations issued conflicting recommendations about the need for immunizations, particularly tetanus. Future flood response efforts should coordinate different agencies or jurisdictions to ensure that public health messages are consistent.

Shelters

The widespread use of emergency and temporary shelters to house flood refugees also posed significant public health concerns. Individuals of all ages, along with their pets, were crowded into church basements, school auditoriums, and other makeshift housing, creating the potential for rapid spread of communicable disease. Lack of adequate hand-washing, cooking, and food-storage facilities compounded the risk. State and local environmental health sanitarians visited shelters to assess physical safety, food-handling practices, water quality, and garbage-disposal arrangements. Public health nurses visited shelters to assess residents' health needs and problems; for example, many residents needed to obtain prescription medications. Epidemiologists worked with shelter staff and local public health agencies to establish a disease surveillance early warning system so potential problems could be identified quickly.

When one shelter accepted home-prepared food and then refrigerated it for only two hours at a time because of lack of space, public health sanitarians intervened. Emergency shelters are routinely instructed not to accept home-prepared foods since the foods cannot be monitored for safety during preparation and transport. Nonhazardous foods like baked cookies, bars, or cakes can be accepted. Only one foodborne disease outbreak was identified while the shelters were in operation, and that outbreak was associated with contaminated home-cooked foods.

Local Public Health Response

Public health agencies in flooded areas prepared for and responded to the flood in a variety of ways. Here are some examples.

Granite Falls/Montevideo: Countryside Public Health Service

Local public health staff were involved in the emergency planning process and are now part of the core group responding to the disaster. Public health nurses worked with the local housing inspector to conduct house-to-house inspections—assessing damage, teaching appropriate cleanup techniques, and helping people bring their homes up to code.

Breckenridge: Wilkin County Public Health Service

Fuel oil has damaged at least 31 homes in the community. Altogether, more than 400 homes and all downtown businesses were affected by the flood. The city hall, the courthouse, most county services, the emergency operations center, and the public health agency were all flooded, and their operations had to be moved elsewhere. The public health response included answering and triaging telephone calls, identifying who would be responsible for homes contaminated with fuel oil, and re-establishing normal activities and procedures for the public health staff.

Ada/Detroit Lakes/Mahnomen: Multi-County Nursing Services

Approximately 1,000 evacuees from the Grand Forks/East Grand Forks area went to Detroit Lakes, and another 1,000 went to Mahnomen County. About one-third of these refugees are expected to remain away from their homes for an extended period. The town of Ada evacuated 1,400 of its 1,700 residents. Sewage and fuel oil were present in many homes. Public health personnel monitored volunteer activities at feeding sites and enforced a local abatement order for garbage removal. Public health staff were involved in emergency response meetings and are now an integral part of the community's flood emergency response.

East Grand Forks: Polk County Public Health Service

Only 5% of the homes and a handful of businesses in East Grand Forks were spared by the floodwaters, and everyone was indirectly affected when the city lost its potable water supply. The entire community was evacuated, and many flood survivors moved into nearby communities, particularly Crookston. Public health personnel focused on coordinating the community's response, ensuring the safety of people in the shelters, giving immunizations, and monitoring the emotional health of flood survivors and volunteers.

University of Maryland

Waste Disposal

Portable toilets used during the flood emergency and garbage pickup at food-service establishments were monitored to assure regular maintenance. Because of the large volume of solid waste, public health personnel recommended that food waste be collected first to avoid attracting rodents and insects. Although homeowners were concerned that flooded belongings be available for insurance adjusters to inspect, local public health officials made it a priority to move potentially hazardous materials out of the area as quickly as possible. In some communities, local health officials worked with waste-disposal companies and local government to provide photographic documentation of damaged items.

Mosquitoes

The spring flooding raises concern about a possible outbreak of mosquito-borne western equine encephalitis (WEE) this summer. Many factors will determine whether an outbreak will occur. The most significant is the amount of rain in the region in June and July. To help assess the risk, public health personnel are trapping and examining mosquitoes in the counties along the Red River as part of a formal surveillance program. Depending on the results of the trapping program, a sentinel surveillance system may need to be established using chickens and horses to monitor for WEE cases.

Food, Beverage, and Lodging

Once public and private agencies have dealt with immediate health and safety concerns, longer-term issues will be considered. Commercial food, beverage, and lodging facilities must meet public health standards for sanitation and safety before they can reopen following a flood. In some instances, this means working with operators to limit menus, e.g., no salad bars at full-service restaurants until sewer services and safe community water supplies are available. Restaurants must be inspected daily under some conditions to reduce the risk of disease transmission and respond to the community's need for restaurant services.

Child Care

In East Grand Forks, working parents and families will need a safe place for their children while they clean and repair their damaged homes and businesses. More than 1,200 child care slots were available in this community before the flood, but space limitations had reduced that number to fewer than 400 by mid-June. A shortage of appropriate child care can lead to an increase in injuries, disease transmission, and emotional trauma for children who don't have a consistent care provider. Public health personnel are working with the community to address this issue.

Mental Health Issues

The total emotional cost of the flooding has yet to be determined. Flood victims will find it difficult to forget leaving their homes in a boat or in the back of a National Guard truck; the helpless hours and days of waiting in the shelter; their fear of losing their neighborhoods and their homes; and the vivid media images of homes in their communities floating off their foundations. The long-term work of cleaning and rebuilding can be overwhelming, and the emotional impact on individuals, families,

Disruption of Health and Medical Services

People affected by the flooding often had to evacuate their homes rapidly, sometimes in the middle of the night, leaving behind medical information, prescription medications, eyeglasses, and other health care necessities. Public health personnel coordinated volunteer agencies, physicians, and pharmacists to address these needs, usually working with limited medical information and access to records and often without any information about reimbursement. Licensed health personnel from other states were able to work in Minnesota under a statutory provision that allows temporary practice in a declared emergency.

A number of health care facilities experienced problems during the flood emergency.

Bridges Medical Center

This combination hospital, nursing home, and clinic in Ada was completely inundated. Public health staff are working with the facility and federal officials to evaluate problems at the facility, including leakage of hydraulic fluid from the elevator system, fuel oil leakage, fecal coliform from sewage backup, mold and fungus growth, and structural damage. Prospects for reopening the facility are slim but will depend on the results of this evaluation. If the facility cannot be reopened, public health personnel will help come up with a plan for meeting both short- and long-term health care needs in this community.

Good Samaritan Center

This nursing home in East Grand Forks also experienced considerable flood damage, requiring an assessment of structural integrity, mechanical systems, and general contamination. Residents of the facility were relocated en masse to the technical college in Thief River Falls. While this was a creative and impressive collaborative effort, it is not a long-term solution. Public health personnel are monitoring health care quality in the temporary facility and helping to arrange alternative placement for residents while the Good Samaritan Center is being evaluated. Again, public health personnel will be involved in determining whether it is safe to reopen the home.

and communities will require continuing attention from health professionals, including public health personnel.

Public Safety Messages

During a crisis, it is vitally important to provide the public with clear messages about how people can protect their health and safety. Brevity and simplicity are essential. As part of the flood response, health and safety messages were disseminated through press releases, brochures, regular media briefings, broadcast public service announcements, and other methods. The MDH set up and operated a dedicated flood Web page on the Internet and produced a series of five flood-related informational brochures. These materials provided information on food handling, drinking-water issues, infectious diseases, and the importance of hand-washing and other aspects of basic hygiene. They also included detailed recommendations and instructions for cleaning up flooded homes and businesses, dealing with potential sewage problems, and protecting the health and safety of flood cleanup volunteers. Public health personnel attended public meetings in flooded communities and in those where flood evacuees were housed to answer questions and assure the public that health-related issues were being assessed.

Emergency Response Planning

Emergency response activities at the state and local level are coordinated through a system of emergency operations centers. The EOCs develop plans for responding to an emergency and bringing community decision-makers together to assess problems, determine how to respond, and implement solutions. The role of public health personnel in these command posts was not consistent across the various jurisdictions affected by the flooding. While public health involvement is not the sole answer, communities that are well-organized and involve all the key players—including public health staff—will have a better chance of resolving the crisis. At the state level, a Minnesota Recovers Disaster Task Force has been established to monitor and respond to flood-related issues. The task force, which includes a Health and Human Services subcommittee, will coordinate long-term recovery efforts, and its work is expected to take more than a year.

Lessons Learned

Before the flooding, the MDH was working on protocols for responding to public health emergencies, with an emphasis on communicable disease outbreaks. The proposed protocols identify roles and responsibilities for state and local public health agencies in responding to outbreaks and preventing further disease transmission. Public health issues that emerged during the flood have highlighted the need for a broader approach. The protocols are being modified to include both a section on communicable disease and a separate section on other community emergencies and potential health threats.

Public health responsibilities in a community disaster include predisaster planning, assessment, technical consultation, and participation in decision-making, as well as enforcement of public health standards. Public health agencies have the capacity to be facilitators and coordinators within affected communities. The spring floods of 1997 highlighted the strengths of Minnesota's public health system but also revealed areas for improvement. The next time Minnesota experiences a 100-year flood, we will be stronger because of the lessons learned from our experience in 1997. MM

All authors are with the Minnesota Department of Health. Agnes Leitheiser is director of the Disease Prevention and Control Division. Jack Korlath is section manager of the Epidemiology Field Services Section in the Disease Prevention and Control Division. Mary Rippke is director of Public Health Nursing in the Community Health Services Division. Mary Sheehan is section manager, Environmental Health Services Section in the Environmental Health Division. Buddy Ferguson is a public information officer.

REFERENCES

1. Crossroads [Newsletter of the Greater Minneapolis Area Chapter, American Red Cross]. Minneapolis: Greater Minneapolis Area Chapter of the American Red Cross, Spring 1997.
2. Minnesota Division of Emergency Management. Recovery report no. 5. St. Paul: Department of Public Safety, 5 June 1997.
3. Public health concerns related to current flooding: fact sheet. Minneapolis: Minnesota Department of Health, 6 May 1997.

It's 4am.
Time to find the job you want.
Unless, of course, you're too tired to lift a finger.

1·800·233·9330

Researching career opportunities takes time that you don't have. And often when you do, no one else is at work to help you. But the new **Practice Opportunity Line** offers an easy, no pressure, confidential way to conduct the search on your own, 24 hours a day. All you have to do is call, follow the prompts and research the openings. Then send a voice mail mini-resume to the opportunities you wish to pursue. It's fast. It's easy. And you're awake anyway.



The Practice Opportunity Line
We're on call for you.

University of Maryland

Five Years of Work-Related Injuries and Fatalities in Minnesota

Agriculture: a High-Risk Industry

Margaret Brown, M.P.H., David Parker, M.D., Elizabeth Seeland, B.S.,
Debora Boyle, D.V.M., Ph.D., and George Wahl, M.S.

ABSTRACT

This report describes the Minnesota Fatality Assessment and Control Evaluation Study (MN FACE), a federally funded initiative to study fatal injuries in the workplace. The purpose of the program is to investigate various types of occupotional fatalities and to identify risk factors that contribute to work-related fatalities. Initially, the MN FACE program only investigated fatalities related to falls, confined spaces, and electrocutions. In 1994, MN FACE also began investigating fatalities associated with agricultural work. Agriculture continues to be one of the nation's most hazardous industries, ranking fourth among industries in the United States at high risk far work-related fatalities. MN FACE investigated 46 agriculture-related fatalities during 1994-95. Forty-one percent of the fatalities involved tractors, and 66% of these accidents were tractor rollovers. Other leading causes of agricultural fatalities included grain bin and manure pit asphyxiations.

The National Institute for Occupational Safety and Health (NIOSH) of the Centers for Disease Control (CDC) established the national Fatality Assessment and Control Evaluation (FACE) program in 1982 to provide technical assistance for identifying and investigating risk factors that contribute to occupational fatalities.

In 1991, as part of the national initiative sponsored by NIOSH, the Minnesota Department of Health received a federal grant called Minnesota Fatality Assessment and Control Evaluation (MN FACE) to study selected fatalities in the workplace. Initially, the MN FACE program only investigated fatalities related to falls, confined spaces,* and electrocutions. In 1994, MN FACE also began investigating fatalities associated with agricultural work. Agriculture continues to be one of the nation's most hazardous industries, ranking fourth among industries in the United States at high risk for work-related fatalities. In 1992, approximately 37 fatalities occurred per 100,000 agricultural workers, and an estimated 140,000 farm workers suffered disabling injuries. The rate of agricultural fatalities is extremely high compared with the rate of seven per 100,000 workers for all industries combined.[1] This article summarizes the overall results of the MN FACE program, focusing primarily on agricultural fatalities since 1994.

*A space with limited openings for entry and exit, with unfavorable natural ventilation, that could contain or produce dangerous air contaminants, and that is not intended for continuous worker occupancy.

Methods

MN FACE compiles surveillance data on all work-related occupational fatalities occurring within the state. Data sources include the Occupational Safety and Health Administration (OSHA) at the Minnesota Department of Labor and Industry, law enforcement agencies, county agriculture extension agencies, county coroners/medical examiners, newspaper clipping services, death certificates, and the Census of Fatal Occupational Injuries (CFOI). CFOI is a surveillance system operated by the U.S. Bureau of Labor Statistics in cooperation with state and other federal agencies. CFOI uses multiple identification sources and includes all fatal work injuries, such as agricultural fatalities, that are not regulated by federal or state agencies.

After receiving a fatality report, FACE investigators determine whether the fatality occurred on the job and was not the result of natural causes. These determinations are made using coroners' reports, death certificates, police records, and data available through interviews with employers and coworkers. FACE investigates a fatality immediately after receiving a report. An investigator requests local law enforcement reports and attempts to arrange a site visit to interview coworkers, employers, and family members.

Results

During 1994-95, 119 occupational fatalities were reported to MN FACE. This number includes motor vehicle crashes and homicides, which were not eligible for MN FACE investigation. During this time, 60 industrial fatalities were eligible for investigation by MN FACE (see Table 1). Victims' ages ranged from 13 to 75,

Table 1

1994-95 Minnesota industrial fatalities

	Event				
Source	**Crush/ struck by**	**Fall**	**Electrocution**	**Drowning/ suffocation**	**Other**
Confined space	—	—	—	2	1
Electric charge	—	—	6	—	—
Water	—	—	—	4	—
Machine	16	1	—	—	1
Other	15	11	—	—	3

Table 2

1994-95 Minnesota agricultural fatalities

	Event			
Source	**Crush/ struck by**	**Fall**	**Suffocation/ asphyxiation**	**Electrocution**
Tractor	18	1	—	—
Grain bin	—	—	4	—
Manure pit	—	—	2	—
Electric charge	—	—	—	2
Livestock	2	—	—	—
Machine	7	1	—	—
Other	5	4	—	—

and 95% were male. Two of the victims were under age 18 at the time of death.

From 1994 to 1996, MN FACE investigated 46 farm work-related fatalities (see Table 2). The majority of these agricultural deaths were associated with tractors (41%), grain bins (9%), or manure pits (4%). The leading cause of tractor-related deaths was tractor rollovers (66%).

Most tractor rollover fatalities did not occur during farming activities associated with crop production, such as soil tilling, planting, crop cultivation, and harvesting. Rather, these incidents occurred during such activities as mowing ditches, transporting hay bales with front-end loaders, and towing heavy loads. The tractors involved in these incidents were 25 to 30 years old and were not equipped with a seat belt or rollover protective structure—a steel bar designed to protect the operator if the vehicle overturns.

Six of the agriculture-related fatalities involved confined spaces. Four victims suffocated in grain bins. One of these victims was under age 18. Two victims were asphyxiated in manure pits.

Discussion

Although the Minnesota Department of Health does not mandate the reporting of agricultural fatalities, MN FACE personnel believe that the numbers presented here represent accurately the occupational agricultural fatalities that occurred in Minnesota during this time period. MN FACE verified that no occupational agricultural fatalities were missed by comparing their occupational fatality statistics with those of CFOI and the Department of Biosystems and Agricultural Engineering at the University of Minnesota. Although these two groups reported a larger number of fatalities than MN FACE, the discrepancy is explained by the groups' differing definitions of an occupational fatality. MN FACE does not include agricultural fatalities involving children who are not working or agricultural fatalities involving nonfarm vehicles on a public roadway.

Tractor rollovers

Nearly all of the tractor rollover fatalities could have been prevented if a rollover protective structure and a seat belt had been in use. Safety restraints, such as seat belts, must be used in conjunction with the rollover protective structure to keep the operator in the protected space.[2]

To encourage the use of rollover protective structures, at least one manufacturer has reduced their price. Seven of the 18 tractors involved in these rollovers could have been equipped with a rollover protective structure. Retrofitting was not possible for two tractors because no rollover protective structure was available. Information about the manufacturers of the other tractors was not available, so investigators could not determine whether these tractors could have been retrofitted with a roll bar.

Grain bin fatalities

Grain bin fatalities most frequently occur as a result of suffocation in flowing grain. These deaths often happen as the bin is being emptied, either mechanically or by gravity.

University of Maryland

Flowing grain forms an inverted cone with strong enveloping forces that can quickly draw a person under the surface of the grain. The number of grain bin suffocations has increased over the past several years, probably because of technological advances that have led to increased storage capacities, larger and faster grain-handling rates, and automation that enables operators to work alone. Six fatal grain bin suffocations occurred in Minnesota during 1996.[3]

To prevent these types of fatalities, grain bins should be identified as confined spaces, and warning signs should be posted at all entrances. If a worker must enter a bin, following confined-space entry procedures, all equipment used to fill or empty the bin should be stopped and the power source should be locked out.[†] Rescue personnel attempting to free a victim from a grain bin should cut large holes into the sides of the bin to allow the grain to spill out. Rescuers should not enter the bin because this increases the flow of grain, further burying the victim and putting the rescue workers in danger themselves.

Manure pit asphyxiations

Livestock production in confinement facilities has led to an increase in manure pit asphyxiation injuries and deaths during the last 15 to 20 years.[4] Farmers may be exposed to the hazards of these pits, which meet NIOSH's confined-space criteria. These hazards include oxygen-deficient, toxic, and/or explosive atmospheres resulting from the fermentation and decomposition of animal waste. Incidents involving entry into confined spaces often result in multiple deaths. Coworkers or others, including family members, who enter the pit in an attempt to rescue initial victims are often killed themselves.[5] National FACE investigations have shown that 39% of the victims in confined-space incidents were coworkers or others who attempted to rescue the initial victim.[6]

NIOSH recommends that manure waste pits be identified as confined spaces and that warning signs be posted at all entrances to these pits. Farm workers should be instructed never to enter manure waste pits without using appropriate safety measures. These include the use of respiratory



[†] The placement of a lockout device at all points where equipment or circuits can be energized, in accordance with an established procedure, ensuring that the circuit and the equipment cannot be energized or operated until the lockout device is removed.

Looking for Two
General Surgeons BE/BC
Opportunity in Minnesota

Join two established general surgeons in a community-based surgical practice at Albert Lea Clinic—Mayo Health System, a 49-provider multi-specialty practice with regional clinics in southern Minnesota and northern Iowa. Located 90 miles south of St. Paul/Minneapolis and 70 miles southwest of Rochester, Albert Lea features a 110-bed hospital, beautiful lake and park areas and excellent school system.

Inquiries
Dr. Clarence Carlson
Diane Clark, RN
800-210-9662
507-377-4826 (fax)

Albert Lea Clinic
Mayo Health System
1602 Fountain Street
Albert Lea, MN 56007

Emergency Physicians

2 Full-Time, permanant BE/BC Emergency or Family Practice Physicians for rotating day and evening hours are needed at St. Francis Hospital in Shakopee, a southwestern suburb.

Urgent Care Physicians

An Urgent Care Center is opening at the above location and another in Chaska, a western suburb. Opportunities for BE/BC Family Practitioners for evening, weekend and holiday hours.

St. Francis Medical Center offers full benefits, competitive salary and paid malpractice.

For Additional Information:
Debbie Modder
Allina Health System
Route 80775
5601 Smetana Drive
Minnetonka, MN 55343
612-992-3094 / 800-248-4921
Fax: 612-992-3669

protection and adherence to safe confined-space entry procedures. When possible, manure waste systems should be designed to provide access to all serviceable parts from outside the pit. Equipment designed for use in manure waste systems should include warnings of the potential hazards associated with worker entry into manure waste pits.

CONCLUSION

Information on the causes of work-related fatalities is essential to developing and implementing prevention programs. Programs such as FACE, which survey and investigate occupational fatalities, are essential for effectively preventing future deaths. To prevent the greatest number of fatalities, research and prevention efforts should focus on the leading causes of workplace fatalities. During the 1980s, electrocutions, one of the leading causes of occupational fatalities, became a primary emphasis of NIOSH's injury prevention program. Changes to the National Electrical Code and to Occupational Safety and Health Administration regulations were implemented, as were public safety awareness campaigns by power companies and others. Worker deaths by electrocution decreased more than any other cause of death during this period.[7]

Agriculture is one of the most hazardous industries in the United States. In 1992, workers in this industry suffered 701 fatalities.[8] This may be explained in part because many farm workers are independently employed and most farms are exempt from generally scheduled OSHA inspections. Efforts to improve surveillance data and to design, implement, and evaluate intervention strategies are urgently needed to provide a safe and healthy working environment for all workers in this country.[9] MM

All authors work for the Minnesota Department of Health. Margaret Brown is a safety investigator. David Parker is a physician and epidemiologist. Elizabeth Seeland is a student worker/paraprofessional. Debora Boyle is a principal epidemiologist. George Wahl is a senior safety investigator.

REFERENCES

1. National Safety Council. Accident facts. Chicago: National Safety Council, 1993.
2. NIOSH. NIOSH reports on the preventability of tractor rollovers. Cincinnati: United States Department of Health and Human Services, Centers for Disease Control and Prevention, National Institute for Occupational Safety and Health, 1993. DHHS (NIOSH) Publication No. 93-119.
3. Wahl GL, Folken SE, Boyle DJ, Parker DL. Suffocations in grain bins—Minnesota, 1992-1995. MMWR 1996;45:837-41.
4. NIOSH. Criteria for a recommended standard: working in confined spaces. Morgantown, West Virginia: United States Department of Health, Education, and Welfare, Public Health Service, Centers for Disease Control, National Institute for Occupational Safety and Health, 1993. DHEW (NIOSH) Publication No. 80-106.
5. Madery G, Parker DL, Shutske J. Fatalities attributed to entering manure waste pits—Minnesota, 1992. MMWR 1993;42:325-29.
6. NIOSH. Request for assistance in preventing deaths of farm workers in manure pits. Cincinnati: United States Department of Health and Human Services, Centers for Disease Control, National Institute for Occupational Safety and Health, 1990. DHHS (NIOSH) Publication No. 90-103.
7. Stout NA, Jenkins L, Pizatella TJ. Occupational injury mortality rates in the United States: changes from 1980 to 1989. Am J Public Health 1996;86:73-7.
8. Bureau of Labor Statistics, in cooperation with federal and state agencies. Census of fatal occupational injuries, 1992 [Brochure]. Washington, DC: U.S. Department of Labor, Bureau of Labor Statistics (undated).
9. Jenkins EL, Kisner SM, Fosbroke DE, et al. Fatal injuries to workers in the United States, 1980-1989: a decade of surveillance, national profile. Cincinnati: United States Department of Health and Human Services, National Institute for Occupational Safety and Health, 1993. DHHS (NIOSH) Publication No. 93-108.

University of Maryland

The Monitor
NEWS FOR MINNESOTA PHYSICIANS

ANNOUNCEMENTS

MARK YOUR CALENDAR FOR THE MMA ANNUAL MEETING

Plan to attend the MMA Annual Meeting at Madden's Resort in Brainerd on Sunday, September 14; Monday, September 15; and Tuesday, September 16. See the July issue of *The Monitor* in *Minnesota Medicine* for a complete schedule of activities.

MMA COSPONSORS CULTURAL COMPETENCE CONFERENCE

"Through the Eyes of Others: Envisioning Culturally Competent Health Care," a two-day conference for health care professionals on cultural competence and sensitivity, is slated for September 19 and 20. The conference, which will run all day Friday and half of Saturday, will take place at the Earle Brown Heritage Center in Brooklyn Center.

The conference is cosponsored by the MMA in conjunction with a number of other health care-related organizations and institutions. The conference will include a health care leadership roundtable, keynote speakers from around the country, and a theater piece entitled "Second Opinion," presented by the Science Museum of Minnesota. To register, contact the Center for Cross-Cultural Health at 612/624-4668.

MMA Leads AMA to Revisit Tobacco Settlement

Due largely to MMA efforts, the AMA has reconsidered its swift acceptance of the proposed tobacco settlement.

At the AMA Annual Meeting in Chicago, the House directed the Board of Trustees to appoint a task force to review the proposed settlement—currently viewed as too weak on tobacco companies by physicians, the Smoke-Free 2000 Coalition, and state Attorney General Hubert Humphrey III. The task force will help press for inclusion of seven key provisions, set forth in the MMA resolution adopted at the meeting:

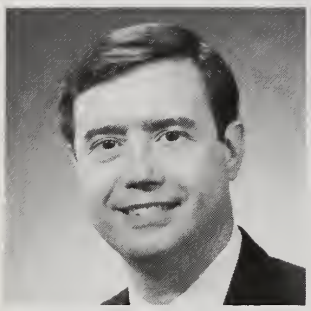
1. No legal immunity for tobacco companies from product liability.
2. Full disclosure of the industry's documents and research regarding nicotine and the harmful effects of tobacco use.
3. Payments that are commensurate with past and continuing harm done by tobacco.
4. Acceptance of Food and Drug Administration regulation of nicotine as a drug.
5. Restrictions guaranteeing that the tobacco industry will not market its products to children.
6. No preemption of state and local laws.
7. A tobacco-industry-funded tobacco use prevention and education campaign.

Initially the AMA Board—along with the American Cancer Society, the American Heart Association, and the National Center for Tobacco-Free Kids—announced support for the tobacco settlement. But at the Annual Meeting, the House of Delegates agreed with the MMA that the board was too hasty in announcing AMA approval.

"We wanted the AMA to take a strong public health position and be in the forefront on this issue," said A. Stuart Hanson, M.D., who chaired Minnesota's delegation. He called the tobacco settlement "the most important public health issue to be settled on the national level in the last 25 years." Physicians and anti-tobacco activists warned that public health organizations must take care not to let a crucial opportunity go up in smoke.

The MMA also contacted Minnesota's congressional delegation, expressing deep dissatisfaction with the current proposed settlement. The letter urged federal lawmakers to reject the settlement, maintaining that any agreement that does not include the seven key provisions is unacceptable.

"The settlement gives far too many concessions to the tobacco companies and will not deter them from attempting to addict future generations of smokers," the letter said. One critical flaw in the settlement, the letter stated, concerns proposed changes in the FDA's authority to regulate nicotine. President Clinton has indicated he is unwilling to sign legislation restricting the government's ability to regulate tobacco products. Nor will he sign, he has said, a settlement that does not have the support of the AMA and other public health groups.



Viewpoint

Timothy J. Crimmins, M.D., Chair
MMA Board of Trustees

Minnesota Takes on the Tobacco Industry

I never thought I would consider several hundred billion dollars not enough money. But the $360 billion proposed to settle lawsuits against the tobacco industry is truly not enough. Tobacco company stocks increased in value after the settlement was proposed—a clear indication that the payment won't make a major dent in profits. We can expect to see the tobacco industry reaping great financial benefits well into the next century.

In a way, it is tempting to accept the money the tobacco industry has agreed to pay for anti-smoking initiatives, such as new warning labels on cigarette packs and free medical help for smokers trying to kick the habit. But a tax-deductible settlement of $360 billion paid out over a period of 25 years won't discourage the tobacco industry from aggressively marketing to a new generation of smokers. Since our goal is to reduce nicotine addiction, we should hold out for a better deal.

It's not surprising that Minnesota Attorney General Hubert Humphrey III stands as the lone voice among the state attorneys general in refusing to settle. Thanks largely to the Coalition for a Smoke-Free Society 2000 and to staunch anti-smoking advocates such as A. Stuart Hanson, M.D., Minnesota has long led the nation in efforts to prevent smoking and provide citizens with a clean, smoke-free environment. When the MMA founded the Smoke-Free Coalition in 1984, I didn't think we could ever reach its ambitious goal. But now, we are well on the way to a nearly smoke-free society in Minnesota's public places and greatly reduced exposure of children to tobacco. When I travel I am amazed by the difference between Minnesota and other states. In some states, it is very difficult to find a restaurant free of second-hand smoke.

Minnesota physicians are playing a highly influential role in determining the fate of the tobacco settlement in Congress and with the president. The Minnesota delegation to the AMA Annual Meeting in June convinced the AMA to shift to a much tougher stance. As a result, the AMA is appointing a task force to recommend policy that must include the following seven recommendations listed in the Minnesota resolution:

1. Full disclosure of the industry's documents and research regarding nicotine and the harmful effects of tobacco use.

2. Payments that are commensurate with past and continuing harm done by tobacco.

3. Acceptance of federal Food and Drug Administration regulation of nicotine as a drug.

4. Restrictions that guarantee the tobacco industry will not market its products to children.

5. No preemption of state and local laws.

6. A tobacco-industry-funded tobacco use prevention and education campaign.

7. No legal immunity from product liability.

Rarely is a proliferation of lawsuits preferable to an out-of-court settlement, but in this case, it would be imprudent to absolve the tobacco companies of all liability for their deadly products. If lawsuits are allowed to go forward, more information will be revealed about the way the tobacco industry has misled the public about the power of tobacco to addict and the danger of tobacco products.

The president's advisory panel headed by former FDA Commissioner David Kessler and former Surgeon General C. Everett Koop, M.D., has also recommended that all currently available avenues of litigation, both civil and criminal, be fully preserved. The panel echoed many of the MMA's recommendations and added important suggestions:

- Any fines or punitive damages imposed on the tobacco industry should not be tax-deductible.
- The U.S. should promote tobacco control worldwide through international organizations and binding treaties.

Despite its need for improvement, the settlement does include some valuable provisions, such as its restrictions on advertising and marketing. The tobacco companies have agreed to phase out Joe Camel, but his legacy lingers on. A study found that 91 percent of 6-year-olds not only recognized Joe Camel, but linked him to cigarettes. Tobacco companies are skillful at promoting cigarettes—especially to youngsters who are swayed by cartoon characters, specialty gift items, and promotional activities such as rock concerts and sporting events. Ninety percent of new smokers are children and teens. It is certainly appropriate to restrict opportunities for the tobacco industry to addict children.

Tobacco is an addictive drug. If companies were introducing cigarettes as a new product today, they would not meet safety standards. Tobacco is an addictive drug that sickens its users over time. • • • • •

University of Maryland

LEGISLATIVE NEWS

Two MMA-Backed Bills Pass in Special Session

The Legislature passed, in its special session, two MMA-supported health care bills that had been vetoed earlier by Gov. Carlson:

DWI Provisions

The Governor initially vetoed the omnibus DWI bill because he opposed the lower blood alcohol content (BAC) standards proposed for minors. During the special session, the Legislature passed a similar DWI bill without the lower standard, which the Governor signed on June 30.

The act adopts stricter penalties for individuals with multiple DWI convictions, and for individuals with BAC over 0.20 percent—double the legal limit of 0.10 percent. It also applies the state's DWI laws to drivers of snowmobiles, motorboats, and all-terrain vehicles (ATVs).

A "zero tolerance" level of alcohol consumption for drivers of school buses and Head Start buses was also included in the bill. The law will now prohibit these drivers from having "any physical evidence present in the person's body of the consumption of any alcohol."

Data Privacy

Gov. Carlson vetoed the Omnibus Data Privacy Bill during the regular session over a provision unrelated to health care. During the special session, the Legislature passed a similar bill without the objectionable provision, and the Governor signed it June 30. The bill includes three provisions that affect health care:

1. One provision clarifies that in medical records that are used for research, patient consent is required only for records released to "an external researcher." Medical records used within a hospital, clinic, or health system do not need consent.

2. Providers must "use reasonable efforts" to obtain patient consent. Reasonable effort is defined as two mailed requests to the patient's last known address with a postage prepaid return envelope, and at least a 60-day waiting period after the last mailing.

3. Licensing boards are required to notify a licensee once a determination is made to investigate a complaint against that licensee. The board does not have to notify the licensee if the board determines that the notice would compromise the investigation.

1997 Legislative Report Available

• • • • • Copies of the MMA's 1997 Legislative Report are now available. Call Wendy O'Donnell at 612/378-1875 or 800/DIAL-MMA.

MMA Acts on Behalf of Physicians

AWARE Contract

The MMA sent out an alert urging physicians to carefully read the AWARE participation agreement, which Blue Cross and Blue Shield claimed would become automatically effective July 1, 1997, unless either party gave notice of termination by June 1. The MMA wanted physicians to take time to carefully review the agreement and to understand its terms. According to the memorandum sent by Blue Cross and Blue Shield, the contract would take effect automatically if physicians took no action. In interviews with reporters, MMA representatives expressed concern that the current trend is to present physicians with take-it-or-leave-it deals, and said physicians would like to see the creation of a legal and appropriate forum for discussions about contracts. Articles appeared in the Twin Cities based *Star Tribune* and the *Pioneer Press*. In addition, Kent Wilson, M.D., MMA president-elect, was interviewed on WCCO-TV.

Utilimed Program

The MMA, in meetings with Medica leaders, raised serious physician concerns about a proposed Medica Diagnostic Imaging Program to be administered through Utilimed. Following these discussions, Medica abandoned its plan to institute a precertification program for certain diagnostic imaging services. The MMA objected particularly to the aspect of the program that would limit access to review criteria only to specific cases under precertification review. Medica officials clearly heard the MMA's contention that Minnesota utilization review law requires much more open access to review criteria.

Highlights of AMA Meeting

Infant Mortality Reporting Remains Unchanged

The Minnesota delegation to the AMA's Annual Meeting expressed disappointment over failure to effect a change in the way the United States reports its infant mortality statistics to the international community. The House of Delegates approved a Board of Trustees report that essentially said, "What we're doing now is OK ... it's meeting our needs," said A. Stuart Hanson, M.D., who chaired Minnesota's delegation. But Minnesota delegates feel that's only partially true.

In the United States, infants weighing 500 grams or more who are born alive are included in the infant mortality rate. Elsewhere, however, infants must weigh at least 1,000 grams to be included in the infant mortality rate.

Advanced technology in the United States sometimes helps very low birthweight babies survive, so most physicians and policymakers agree—for reasons ranging from scientific accuracy to tax policy—that it is important to count them. But the problem arises when those U.S. numbers are reported to the rest of the world; the inclusion of lower-birthweight infants makes the U.S. infant mortality rate seem higher, compared with other nations, than it actually is.

The Minnesota delegation proposed that the United States continue to count infants weighing 500 grams or more for domestic purposes, but use the 1,000-gram minimum when reporting infant mortality rates to the rest of the world, "so we're comparing apples and apples," Hanson said.

The Board of Trustees report was intended to respond to a resolution introduced at the Interim 1996 Meeting, in which the Minnesota delegation called for a task force to address the difference in reporting infant mortality rates.

Minnesota Delegates Part with AMA on Late-Term Abortion Ban

Minnesota's delegation was in the minority opposing a Board of Trustees report that recommends banning a particular, controversial late-term abortion procedure, said A. Stuart Hanson, M.D. The House of Delegates' acceptance of the report resulted in the AMA backing congressional legislation that would outlaw intact dilation and extraction and impose criminal penalties on doctors who perform the procedure.

The AMA pledged to work at the federal and state levels to remove the criminal penalties against physicians, a compromise that led a majority of delegates to support the board. Support of the bill as written represented the second time in its 150-year history that the AMA has backed legislation making a medical procedure a crime.

Hanson, chair of the Minnesota delegation, said the AMA Board of Trustees did not believe the ban constituted a departure from accepted policy, and that's where the Minnesota delegation's interpretation differed from the board's. "The AMA report supports banning a medical procedure. The Board of Trustees did not think that was a change in policy," Hanson said.

But the Minnesota delegation's understanding of AMA and MMA position is that decisions about "medically appropriate care," which in some cases may include abortion, should be made solely between physicians and patients. Hanson said Minnesota delegates felt that the ban, by allowing governmental intrusion into medical decision-making, contradicts the policy they are obliged to uphold.

The report generated five hours of civil but passionate debate before the house and a standing-room-only reference committee. President Clinton has vowed to veto legislation banning intact dilation and extraction, but its backers in Congress believe that with a modified bill they can win enough votes to override a veto.

(Highlights continued on page 37)



A. Stuart Hanson, M.D.; C. Randall Nelms, Jr., M.D.; Frank J. Indihar, M.D.; Robert D. Christensen, M.D.; Andrew J. K. Smith, M.D.; Thomas L. Peyla, M.D.; Ben P. Owens, M.D.; Carolyn J. McKay, M.D.; Audrey M. Nelson, M.D.; Lyle Munneke, M.D.; Jasper R. Daube, M.D.; Bruce A. Norback, M.D.; William R. Kennedy, M.D.; and Raymond G. Christensen, M.D.

University of Maryland

Minnesota Physicians at AMA Annual Meeting

At the June American Medical Association Annual Meeting, Minnesota delegate Ben P. Owens, M.D., chaired Reference Committee D, which addressed public health issues, including the controversial tobacco settlement. Eric G. Tangalos, M.D., a delegate for the American Medical Directors Association, chaired the AMA Reference Committee on Amendments to Constitution and Bylaws, and Lisa H. Fish, M.D., representing the Endocrine Society, served on that committee. Andrew J. K. Smith, M.D., served on Reference Committee C, which addressed medical education and work force issues. William E. Jacott, M.D., was active as an AMA trustee. Minnesota alternate delegate John M. Van Etta, M.D., served as a teller.

The Minnesota delegation, chaired by A. Stuart Hanson, M.D., included delegates Robert D. Christensen, M.D.; Frank J. Indihar, M.D.; Carolyn J. McKay, M.D.; Andrew J. K. Smith, M.D.; Audrey M. Nelson, M.D.; Ben P. Owens, M.D.; and alternate delegates Raymond G. Christensen, M.D.; Kenneth W. Crabb, M.D.; Theodore L. Fritsche, M.D.; Thomas L. Peyla, M.D.; John M. Van Etta, M.D.; Bruce A. Norback, M.D.; and Lyle Munneke, M.D.

Specialty delegates from Minnesota included Jasper R. Daube, M.D., American Association of Electrodiagnostic Medicine; C. Randall Nelms, Jr., M.D., American Academy of Otolaryngology; William R. Kennedy, M.D., American Academy of Neurology; Peter R. Wilson, M.D., American Academy of Pain Medicine; Joseph M. Keenan, M.D., American Geriatrics Society; Mark R. Pittelkow, M.D., Society for Investigative Dermatology; Eric G. Tangalos, M.D., American Medical Directors Association; Michael J. Murray, M.D., Society of Critical Care Medicine; Lisa H. Fish, M.D., Endocrine Society; and Richard B. Tompkins, M.D., American Medical Group Association.

Highlights *continued from page 36*

Human Rights Resolution

The Minnesota delegation supported the AMA House of Delegates' adoption of a substitute resolution that calls on the government of Turkey to "cease all prosecutions of the Human Rights Foundation of Turkey (HRFT) and all other actions that impede its work." The resolution was adopted after testimony about Tufan Köse, M.D., who was convicted and fined for refusing to reveal to Turkish authorities the names of torture survivors who came to him for treatment, and about the Turkish government's attempts to close down the Human Rights Foundation of Turkey. The AMA has a long history of opposing human rights violations; a year ago the organization sent a letter to the Turkish Minister of Foreign Affairs expressing concern about alleged harassment of HRFT members. The AMA also works through and supports World Medical Association activities on behalf of HRFT and deploring the persecution of Dr. Köse.

AMA Elections

Nancy W. Dickey, M.D., became the American Medical Association's first female president-elect. Dickey has been an AMA board chair for two years and has been active in the AMA for 20 years—only missing one AMA meeting since 1978. Dickey also has been an active member of the Texas Medical Association.

Percy Wootton, M.D., became the 152nd president of the AMA, and P. John Seward, M.D., became executive vice president. Two newcomers joined the Board of Trustees: Herman Abromowitz, M.D., and Andrew Thomas, M.D. All board members up for re-election retained their seats.

Use of Term 'Physician'

After much discussion, the AMA House of Delegates voted to adopt an amended resolution regarding the term "physician," advocating tight restriction of its use.

The reference committee honed the resolution, which originally called for the AMA "to seek legislation prohibiting the use of the term 'physician' as a descriptor other than in the context of a medical doctor of medicine (MD) or a doctor of osteopathy (DO) with the exception of 'physician's assistant.'" The committee recommended that the "physician's assistant" exception be deleted.

This year, the MMA introduced a bill in the state Legislature that would have made clear that the use of "physician," alone or combined with any other term, would be prohibited unless the use of the term were allowed elsewhere in statute. The bill did not pass.

By itself, "physician" can only be used by medical doctors or doctors of osteopathy in Minnesota. But the Podiatric Practice Act—which was strongly opposed by the Minnesota Chiropractic Association and the Minnesota Optometric Association—allows use of the terms "podiatric physician" and "physician assistant." Action on that legislation is anticipated in the 1998 legislative session.

Memorial Established for Dr. James Todd

James S. Todd, M.D., former executive vice president of the American Medical Association, died June 24 in New Jersey just as the AMA House of Delegates, celebrating the AMA's 150th anniversary, was meeting in Chicago. "James S. Todd served American medicine and the AMA with vigor, integrity, compassion and joy," said Nancy W. Dickey, M.D., chair of the AMA Board of Trustees.

The AMA has established the James Todd Memorial Scholarship at Harvard Medical School in his memory. Contributions may be sent to the AMA, 515 North State Street, Chicago, Illinois 60610, Attn: James Todd Memorial Scholarship.

• • • • •

Geographic Coalition Efforts Fuel Congressional Action

A House and Senate conference committee is reconciling differences in three versions of Medicare legislation—all of which call for lessening the wide geographic disparities in payment rates to Medicare managed care organizations. MMA health policy analyst Janet Silversmith said that even in the worst-case scenario, the final bill will be an improvement over the current payment system.

"There's a pretty broad sentiment that there will be a reduction in the variation," Silversmith said, adding that the question now is how significant it will be.

Silversmith is coordinator of the Geographic Coalition, a nonpartisan group of state medical associations committed to achieving a more equitable Medicare reimbursement system. In late June the Coalition contacted every member of the U.S. House and the Senate, urging support for making AAPCC (adjusted average per capita cost) rates a 50-50 blend of national and local rates. The Coalition also asked lawmakers to institute a minimum payment floor in 1998 to more quickly reduce the variation.

On the Senate side, both of those provisions were approved, with the 50-50 blend formula to be phased in over five years. Sen. Charles Grassley, R-Iowa, sponsored an amendment that sets the payment floor at 85 percent of the national average (about $400). Silversmith noted that Iowa is one of the 24 Geographic Coalition states.

Of the conference committee's 20 members, three are from Geographic Coalition states: Iowa's Grassley, Kent Conrad, D-North Dakota, and Bill Archer, R-Texas.

In the House Ways and Means Committee version, the 50-50 blend was also approved; but in the House Commerce Committee version, a less desirable 70-30 blend of local and national rates was adopted. In both House versions, the payment floor would be set at $350, rather than at 85 percent of the national average. Currently, Medicare pays less than $350 per month per senior citizen in 75 of Minnesota's 87 counties.

In the Senate package, AAPCC rates would be adjusted for new enrollees, who presumably are healthiest among all enrollees. House legislation would mandate changes in the way risk adjustments are made in the payment formulas by the year 2001. Under the current risk adjustment system, which only takes demographics—not health status—into account, an HMO receives a higher payment for enrolling a healthy 80-year-old than for an unhealthy 65-year-old. The Geographic Coalition supports the immediate incorporation of a health status measure into Medicare's risk adjustment system.

The Senate and the House Commerce Committee versions both call for removing the GME/DSH (graduate medical education and disproportionate share) payments from the AAPCC rates by 2002. Instead, that money would be channeled directly to the facilities, taking control of those funds away from managed care organizations. Organized medicine generally supports removing GME/DSH funds from AAPCC rates; as expected, the managed care industry

(Coalition continued on page 39)

AMA Highlights Concerns in Medicare Legislation

• • • • • The House-Senate conference committee is also reconciling other differences in Medicare legislation approved by the Senate Finance Committee, the House Ways and Means Committee, and the House Commerce Committee. The AMA highlighted the following issues as being of particular concern to physicians:

- Keeping the Medicare physician conversion factor at $37.13 in 1998, and supporting a physician update formula that covers practice cost increases beyond doctors' control.
- Keeping the practice expense language in the House Commerce Committee version, which provides a one-year delay with appropriate direction to the Health Care Financing Administration to review the methodology.
- Eliminating the dual-eligibles provision in the Senate Finance Committee version, which could result in as much as a 20 percent reduction in Medicare payments to doctors for treating low-income seniors.
- Keeping "affiliation" language in the Senate bill, which will allow needed flexibility in PSO (provider-sponsored organization) management and ownership structure, and federal certification and oversight of PSOs with strong, uniform federal consumer protection standards.
- Keeping the House language that calls for professional liability reforms, including a $250,000 cap on noneconomic damages.
- Keeping patient protections in the House Commerce Committee version, including: language ensuring that the length of an inpatient hospital stay is determined by the attending physician, language limiting "anti-gag" provisions, and language guaranteeing seniors the right to purchase health care services outside of the Medicare program.

University of Maryland

Coalition *continued from page 38*

vigorously opposes the idea. In fact, the American Association of Health Plans (AAHP) supports the House Ways and Means proposal that includes the 50/50 blend because GME and DSH are not removed. The impact in some urban areas is greater from the removal of GME and DSH funds than the benefits under a 70/30 blend.

The final legislation is bound to bring better access, a broader range of benefits, and increased preventive care for rural seniors in Minnesota and around the country. Under any of the proposals, all of Minnesota's counties would benefit; however, the greatest potential benefit exists under the 50/50 blend proposals. Even Minnesota's highest paid counties (Ramsey and Olmsted) would benefit. The conferees are expected to bring a compromise bill back to the House and Senate by mid-August.

Silversmith said she spoke to Geographic Coalition state representatives in June at the annual AMA meeting in Chicago, updating them on the status of their efforts in Congress and urging them to continue lobbying their own senators and representatives.

"The message was ... now it's up to individual states to go and hammer the message home," she said.

• • • • •

MDH Has Flood-Related Health Information

• • • • • INFORMATION ABOUT flood-related health concerns is offered by the Minnesota Department of Health in a number of brochures, and online at the following address: http://dpc.health.state.mn.us/flood.htm

For printed copies of flood-related health brochures or news releases, or if you have any questions, call Aggie Leitheiser at (612) 623-5709.

Supreme Court Finds No 'Right to Die'

The U.S. Supreme Court ruled June 26 that terminally ill Americans do not have a constitutional right to physician-assisted suicide, upholding state laws that forbid doctors to give lethal drugs to dying patients who want to hasten their deaths.

However, the ruling does not prevent individual states from deciding how to regulate assisted suicide. Nor does it prohibit physicians from prescribing potent drugs for pain, even if those drugs might also have the effect of hastening death.

Earlier, the U.S. Courts of Appeals for the Ninth and Second Circuits ruled that banning doctor-assisted suicide violates constitutional rights, and that there is no legal distinction between refusing treatment and taking drugs to end one's life. But the Supreme Court concluded that there is, in fact, a distinction, and it derives from long-held legal concepts of causation and intent.

"The law has long used actors' intent or purpose to distinguish between two acts that may have the same result," the court wrote. Patients' right to refuse life-sustaining treatment originates from the common law concept that forced treatment is a battery, the court said, but there is no common law right to commit suicide. Assisting suicide is a crime in Minnesota.

The MMA is opposed to physician-assisted suicide. The MMA Committee on Ethics and Medical-Legal Affairs is working on its paper describing the differences between withholding or withdrawing treatment and assisting suicide, said Patricia Franklin, director of legal affairs for the MMA. The MMA Board of Trustees is slated to review the paper in August.

The AMA issued a statement at its annual meeting supporting the Supreme Court decision, taking the position that assisting suicide is not compatible with the physician's role as healer. The AMA is developing both an educational and a legislative plan of action to help states address the issue. The educational program—the Compassionate, Competent Care Initiative—will be designed to help ensure that physicians are properly equipped to care for dying patients, and that patients are informed about end-of-life options. • • • • •

New TV Rating System Applauded

In a July 10 interview on KARE-11, Timothy J. Crimmins, M.D., chair of the MMA Board of Trustees, applauded the agreement between the television industry and child advocacy groups to expand the present television rating system.

In answer to growing public concern about the harmful influence of some television programming on children, all major broadcast and cable networks, except NBC, agreed to use additional code letters in rating their shows: V for violence, S for sexual content, L for vulgar language, D for suggestive dialogue, and on children's shows, FV for fantasy violence.

The AMA heralded the agreement as a great improvement over the previous proposal, which was limited to indicating age appropriateness. The expanded rating system, slated to take effect in the fall, may be used in conjunction with V-chip electronic blocking devices that will be installed on new television sets starting early next year. The AMA and other advocacy groups pledged to help educate the public about V-chips and the parental guidelines system.

• • • • •

HTAC NEWS

HTAC Issues Report on Newborn Hearing Screening

The Health Technology Advisory Committee has just released a report recommending hearing tests for all newborn infants.

HTAC estimates that nearly 200 babies are born with hearing loss in Minnesota each year. The report recommends universal testing—rather than just testing of infants determined to be "high-risk" (due to factors such as low birthweight, family history of hearing loss, and infections during pregnancy)—because high-risk newborns account for only half of all infants with hearing loss at birth. In addition, HTAC predicts that the costs of universal testing will not substantially outweigh the costs of screening only high-risk infants.

The report proposes otoacoustic emission (OAE) screening of all newborns, followed by auditory brainstem response (ABR) testing for those infants suspected of having hearing loss on the basis of the OAE test. OAE testing uses a probe placed within the infant's ear to measure inner-ear responses to sound. This method has also been endorsed by the National Institutes of Health as being highly accurate for infants under 6 months of age.

The report discusses many potential benefits of newborn hearing screening, particularly from improved language and communication skills due to early identification and treatment of infants with hearing loss. It suggests that OAE screening could be administered by paraprofessionals or volunteers, with consultation and oversight by appropriately trained, skilled professionals including audiologists. Additional diagnostic testing and/or treatment should be administered by suitably trained professionals, the report states.

HTAC reported preliminary findings on the matter to a legislative health committee last session, and lawmakers appropriated $18,000 for 1998 to develop a work group to implement a voluntary plan for hospitals to screen all infants for hearing loss. The work group will include six MMA representatives from pediatrics, family practice, and ENT. It will also include parents, audiologists, and representatives from hospitals and health plans. HTAC Director David Haugen said HTAC plans to help the work group establish the hearing loss screening plan and will make its report available to the group.

HTAC is an independent body that evaluates new and existing—and often controversial or costly—health technologies. HTAC considers issues of safety, clinical effectiveness, health outcomes, and expense to determine whether benefits to patients and society outweigh risks and costs. Created in 1992 as an advisory committee to the recently disbanded Minnesota Health Care Commission, HTAC now reports its findings to the bipartisan Legislative Oversight Commission on Health Care Access. It also works in conjunction with the state commissioner of health and the Health Department. HTAC is composed of 18 volunteers, many of whom work in health care professions.

To obtain a copy of HTAC's report, contact Nancy Cusick at 612/282-6374.

Past HTAC Reports Include:

- Lung volume reduction surgery, 1997;
- Neuroimaging to evaluate headache, 1996;
- Fetal heart rate assessment during labor, 1996;
- Post-delivery care and stabilization of mother and newborn, 1996;
- Cadaver donor pancreas transplants for poorly controlled type I diabetes, 1996;
- Bone marrow transplantation with high-dose chemotherapy for breast cancer, 1996;
- Stereotactic radiosurgery: neurological applications, 1995;
- Prostate specific antigen (PSA) as a routine prostate cancer screening test, 1995;
- Thrombolytic therapy for acute myocardial infarction, 1994.

To obtain copies of any of these reports, contact Nancy Cusick at 612/282-6374.

Currently, HTAC is working on reports analyzing:

- Ultrafast computed tomography (UFCT) for detection of coronary artery disease,
- Bone density screening for osteoporosis,
- Genetic testing for breast cancer.

The Monitor
AUGUST 1997

President
Raymond G. Christensen, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Editor
Lorrie Holmgren

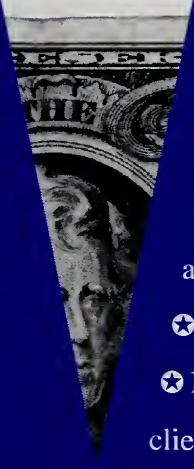
Writer
Susan Maas

University of Maryland

DID YOU KNOW THAT MMBR'S EMPLOYEE BENEFITS TEAM CAN HELP YOU

BRIDGE THE GAP





Did you know that MMBR, the resource company owned by the Minnesota Medical Association and Hennepin Medical Society, can really help you with the challenges of providing employee benefits?

That's right. Because providing services to medical professionals is our only specialty, you can be sure that MMBR will do a great job in helping you design and obtain quality benefit plans for your practice.

Join the many other medical practices who count on MMBR for employee benefit plans such as:

- ✪ Group medical, dental, disability and life coverage
- ✪ Qualified retirement plans
- ✪ Educational personal finance seminars for your employees
- ✪ Personal financial reviews for physicians and staff
- ✪ Voluntary benefits such as life, disability, and long term care insurance
- ✪ Payroll deduction auto and home insurance
- ✪ Free COBRA administration for MMBR group clients

We work to make bridging the gap convenient and cost effective.

Call Barry Weber or Dan Hagberg today at

800-298-6627

MMBR

Minnesota Medical Business Resources
Owned By MMA & HMS

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.

3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

University of Maryland

Tetanus: A Case Report

Ann C. Sudoh, B.A.

ABSTRACT

Tetanus is a rare disease in the United States, with only 40 to 60 cases reported annually. This potentially lethal disease affects unimmunized or partially immunized persons, with the elderly at greatest risk. Tetanus usually follows an injury such as a puncture wound, abrasion, or laceration. The pathogen is an anaerobic, spare-forming, gram-negative, ubiquitous bacillus known as *Clostridium tetani*. In the vegetative form, it produces a lethal toxin, tetanospasmin, which enters the central nervous system through retrograde axonal transport, resulting in characteristic muscle spasms and tonic contractions. Severe tetanus can cause autonomic instability, respiratory arrest, and cardiac arrest.

Patients with tetanus usually require intensive care with close monitoring and extensive supportive care. Most patients experience full recovery with no signs of neurological sequelae. This case report and discussion illustrate the severity of the disease and the complexity of managing a patient with tetanus.

Tetanus is a vaccine-preventable disease infrequently seen in the United States. About 40 to 60 cases are reported annually. Affected persons are either not immunized or only partially immunized. Approximately 70% of these patients are 50 years of age or older, indicating that the elderly are at greatest risk.[1] Only 27.8% of patients 70 years of age or older are adequately immunized for tetanus. In comparison, 82.2% of children aged 6 to 16 years are properly immunized.[2] The following case report illustrates the complex clinical course of a severe case of tetanus and the current treatment and management methods involved.

Case Report

A 68-year-old man came to a local clinic with complaints of a stiff jaw and thick tongue. Seven days earlier, he had stepped on a rusty nail in his pig barn. The nail penetrated his shoe sole and punctured his left foot. His tetanus immunization was not current, and he had refused to obtain either a tetanus booster or other medical intervention, despite his wife's request. He had remained in his usual state of health for seven days, but on the morning of presentation he began experiencing dysphagia and jaw stiffness. These symptoms worsened throughout the day and were accompanied by a thickened tongue, impaired speech, and difficulty chewing. Physical examination revealed an obvious puncture wound on the sole of the patient's left foot that appeared slightly inflamed and erythematous. The patient was afebrile, with a normal pulse and respiratory rate, but his blood pressure was elevated at 172/104. His speech was slurred, jaw opening was limited, and he complained of mild muscle stiffness in his shoulder girdle. He was diagnosed with tetanus and admitted to the hospital.

On admission, the patient was given 5,250 units of human tetanus immune globulin intramuscularly and started on intravenous metronidazole. Cefazolin and ciprofloxacin were administered intravenously for cellulitis. The wound was debrided, and cultures from the site produced a few coagulase-negative *Staphylococci*.

On the second day of admission, the patient had markedly increased dysphagia and had difficulty handling his secretions. Ambulation was limited, and he began complaining of muscle rigidity in all extremities. After he was transferred to the intensive care unit for closer monitoring, the patient's breathing became labored, and intubation was required to maintain his airway. Increasing muscle spasms were controlled with benzodiazepines in the form of a midazolam hydrochloride drip. By the fourth day of admission, tetanic contractions involving the chest wall became more severe, which further compromised his respiration. The patient was placed on a ventilator, and neuromuscular blockade with pancuronium bromide was initiated. Benzodiazepines were continued for patient comfort, and a tracheostomy was performed for long-term ventilatory support. The patient developed pneumonia, which was treated with intravenous clindamycin.

Following initiation of neuromuscular blockade, complications related to autonomic dysfunction developed. Tachycardia and labile hypertension were treated with beta-adrenergic blockers, with variable success. On the 12th day of admission, the patient experienced an episode of sinus bradycardia followed

by a brief period of asystole and hypotension. Evaluation showed no evidence of myocardial infarction or pulmonary embolism, and this event was thought to be due to autonomic instability secondary to tetanus. Because the literature suggested the possibility of precipitating cardiac events with beta-adrenergic blockers, these were discontinued. Intravenous morphine sulfate successfully controlled the tetanus-associated increase in sympathetic activity, with no further cardiac complications. The patient was fed primarily through a percutaneous endoscopic gastrostomy tube. Short periods of total parenteral nutrition were also given because the patient was experiencing periods of intermittent ileus.

The patient was gradually weaned from the pancuronium bromide after four weeks of neuromuscular blockade. He experienced minimal spasms, and by the sixth week of admission, he was weaned off benzodiazepines, allowing a decrease in ventilatory support. By the seventh week of admission, the patient was completely weaned off the ventilator. Once tetanic contractions subsided, he was started on a physical therapy regimen. After the eighth week of hospitalization, he received the first dose of the primary tetanus immunization series and was transferred to a rehabilitation center for further recovery. The patient's gait and speech continue to improve, and he exhibits little evidence of other neurologic sequelae.

Discussion

Pathogenesis

Tetanus, which usually follows an injury such as a puncture wound, abrasion, or laceration, has also been reported following childbirth, abortion, surgery, burns, frostbite, ear infections, or subcutaneous drug use known as "skin popping."[1-4] The pathogen, *Clostridium tetani*, is a gram-positive, anaerobic, ubiquitous, spore-forming bacillus more common in warmer climates. It is found in soil, dust, manure, clothing, and even in 10% to 25% of human intestinal tracts. In the spore form, *C. tetani* is highly resistant to extreme temperatures, oxygen, and moisture. It is, however, not usually infectious in this form. Once the proper anaerobic conditions are attained, the spores begin to germinate and become highly infectious. Anaerobic conditions exist in areas with low oxidation potential, like puncture wounds, foreign bodies, devitalized tissue, or active infection. Upon germination, *C. tetani* releases the exotoxins tetanolysin and tetanospasmin. Tetanolysin is thought to contribute to cell damage and disrupt cell membranes.[4] Tetanospasmin is lethal and the main culprit for the clinical manifestations of tetanus.[1,3-5]

As *C. tetani* proliferates, tetanospasmin is released into the wound and binds to peripheral alpha motor neurons. Through retrograde intraneuronal axon transport, the toxin migrates and concentrates in the nerve nucleus in the central nervous system. Here, the toxin is released and taken up by inhibitory neurons. Thus, release of inhibitory neurotransmitters that normally control muscle spasm, specifically gamma-aminobutyric acid (GABA) and glycine, are blocked. Without this inhibition, firing is unrestrained, resulting in sustained muscle contractions. This loss of inhibition can also affect the sympathetic neurons, producing increased sympathetic activity and catecholamine release.[3,5]

There are four common forms of tetanus: local, cephalic, neonatal, and generalized. Local tetanus affects only the nerves surrounding the injury site, producing localized muscle rigidity. Cephalic tetanus is an uncommon form of localized tetanus that usually follows otitis media or head trauma. Trismus and cranial palsies often involve the seventh (the facial) nerve. Both local and cephalic tetanus can progress to the generalized form. Neonatal tetanus presents as generalized tetanus in infants. This is rare in the United States but is a major cause of infant mortality in developing countries. It is associated with poor maternal immunization and unsterile treatment of the umbilical stump.[3-5] Generalized tetanus occurs when toxin enters the bloodstream and spreads to other neurons. Tetanospasmin cannot cross the blood-brain barrier, so the patient's mental faculties remain intact throughout the course of the disease. With generalized tetanus, head and face muscles are affected first, followed by muscles of the trunk and extremities; the hands and feet are usually spared because of equal axonal transport time, which causes the short nerves to be affected before the long nerves.[3]

Clinical Presentation

The incubation of *C. tetani* from the time of injury is seven to 21 days. Symptoms begin with stiffness of voluntary muscles.[1] Muscles innervated by nerves with shorter pathways are affected first, including muscles of mastication and facial and cervical muscles. Initial symptoms may include local or generalized weakness with difficulties swallowing or chewing. Patients usually complain of difficulty opening their jaw (trismus or "lockjaw") and say their tongue feels as if it is thickening. Dysphagia, along with neck and upper back muscular stiffness, are also common early symptoms. On occasion, facial involvement will result in a "sardonic smile" (*risus sardonicus*).[1,3-5]

As axonal transport of the toxin continues, muscles innervated by longer neuronal pathways are affected. Spasm of the back muscles can cause opisthotonos, a combination of an arched back, flexed and adducted arms, clenched fists on the thorax, and extended lower extremities.[5] A common feature of tetanus is reflex spasms, or waves of tonic contractions, precipitated by minor stimuli, such as noise, light, or touch. These spasms can become severe enough to cause vertebral or long bone fractures and insertional detachments of tendons. Systemic contractions may affect respiration muscles, resulting in acute respiratory distress.[3] Autonomic involvement including arrhythmia, oscillating blood pressure, diaphoresis, rhabdomyolysis, laryngeal spasm, hyperthermia, and urinary retention indicate severe disease. Other serious complications include bacterial superinfections, pulmonary embolism, respiratory failure, and cardiac arrest.[1]

University of Maryland

Diagnosis

A tetanus diagnosis is made primarily by clinical observation. *C. tetani* is rarely recovered from the wound, so cultures may not produce a diagnosis.[3,5] A history of recent immunization with serum antitoxin levels of greater than 0.01 units/ml makes the diagnosis less likely. Electromyography may show the silent interval between action potentials to be either shortened or absent.[3] The differential diagnosis depends on dominant clinical features and can include dental abscesses, seizure disorder, meningitis, hypocalcemic or alkalotic tetany, alcohol withdrawal, or strychnine poisoning.[4-5]

Treatment

Initial treatment of tetanus involves neutralization of unbound toxin and elimination of the toxin source. Human tetanus immune globulin (HTIG) in doses of 3,000 to 6,000 units intramuscularly will neutralize unbound toxin in the wound or in circulation. Toxin already bound to neuronal pathways is not affected and cannot be neutralized. Thus, early administration of the antitoxin is imperative.[3,4] Equine tetanus immune globulin (ETIG) has been known to be effective in doses of 10,000 to 100,000 units intravenously or intramuscularly. Although cheaper than HTIG, it has a shorter half-life and increased rates of hypersensitivity and serum sickness.[1,3]

Wound debridement and antibiotics are used to eliminate the source of toxin. Penicillin G in high intravenous doses of 10 million to 12 million units daily for 10 days has been the antibiotic of choice, but it has a centrally acting GABA-antagonistic effect and can act synergistically with tetanospasmin to worsen symptoms.[5] Metronidazole is now becoming the first-line antibiotic.[1,3-5]

Most tetanus treatment consists of supportive care, including prevention of spasm, airway protection, and treatment of autonomic instability. Patients are usually admitted to the intensive care unit for close monitoring. External stimuli, such as lights, noise, movement, and touch, are minimized to prevent spasms. The GABAergic effects of benzodiazepines, such as diazepam, can control mild spasm and reduce anxiety. When tonic contractions become generalized and more severe, neuromuscular blockade with vecuronium or pancuronium may be warranted.[3-5] Because tetanospasmin does not cross the blood-brain barrier, the patient's mental faculties remain intact throughout the course of the disease. The patient is fully aware of the excruciating pain associated with tonic contractions—one of the terrors of tetanus and a detail that should not be missed.[5]

The combination of trismus, dysphagia, laryngeal spasm, respiratory muscle spasm, and sedatives commonly leads to respiratory complications.[1] Early intubation or tracheostomy, with or without mechanical ventilation, will provide airway protection.[3] Pneumonia is a common cause of death associated with tetanus, so careful attention to pulmonary hygiene is necessary.[1,5] Autonomic instability in severe tetanus may lead to labile hypertension, tachycardia, arrhythmias, and cardiac arrest. Control of these symptoms with alpha-adrenergic blockers, beta-adrenergic blockers, or combined alpha- and beta-adrenergic blockers has been suggested.[5] However, there have been some reports of cardiac arrhythmias, hypotension, and cardiac arrest precipitated by these agents.[5-7] Intravenous morphine sulfate has effectively controlled hypertension secondary to autonomic instability, with less mortality. The actions of morphine sulfate are complex, but it works basically to block sympathetic peripheral venous constriction and induce peripheral arteriolar dilation.[5,6] Magnesium sulfate is also effective, with its ability to vasodilate and inhibit catecholamine release. Magnesium sulfate must be given with sedation, however, since it is not effective alone.[6,7]

Prognosis

Overall mortality for generalized tetanus in the United States is 25% to 50% depending on such factors as age, form of tetanus, and period of incubation and onset.[1,3,4] Patients with moderate to severe disease, including trismus, dysphagia, intermittent muscle spasms, rigidity, and respiratory distress, generally require three to six weeks of intensive care followed by several months of physical rehabilitation. Despite the complicated course, patients usually experience full recovery with no signs of residual neurological sequelae.[3,5]

Prevention

The key to tetanus prevention is proper immunization and wound care. The majority of tetanus cases in the United States occur in people who are either not immunized or only partially immunized; elderly people represent a large proportion of this population. Active immunization in infants and children with diphtheria, tetanus, and pertussis toxoids (DTP) at ages 2, 4, 6, and 15 months of age followed by a booster at 4 to 6 years of age is recommended.[5] At age 7 and older, primary immunization consists of a series of three injections. The first and second injections are four weeks apart, and the third injection is given six months after the second.

Tetanus and diphtheria toxoid (Td) boosters are then administered every 10 years. Persons who develop tetanus require a full primary immunization series upon stabilization of symptoms. The amount of toxin that causes even the most severe case of tetanus is not enough to produce lasting immunity.[5]

Wound management is also important in disease prevention. Necrotic tissue and foreign bodies should be removed and purulent tissue drained promptly. Antibiotic prophylaxis may also be considered. Patients with tetanus-prone wounds who are not adequately immunized should receive passive immunization with 250 to 500 units of intramuscular HTIG or 1,500 to 5,000 units of intramuscular ETIG. MM

Acknowledgment

The patient in this case report was cared for by the physicians and staff of St. Joseph's Hospital in Park Rapids, Minnesota. I wish to thank Dr. Gregory J. Sperle for bringing my attention to this patient, Dr. John R. Lageson for allowing me to participate in the care of this patient and encouraging me to write this case

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Occupational Health
Ob/Gyn
Pediatrics

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES

ASPEN Medical Group

Full Time Urgent Care

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

Red Lake, Minnesota

MAKE A DIFFERENCE!

Medical Director and full-time staff opportunities are available at Red Lake Hospital, operated by the Indian Health Service. Approximately 40-50 patients are seen per day, only 10-15% emergent care and 85-90% urgent care. 24 hour shifts are available.

Red Lake, Minnesota is within close proximity to Grand Rapids and a 35-minute commute to Bemidji.

Spectrum offers:
- •competitive remuneration
- •occurrence based malpractice insurance

Medical Directors also receive:
- •comprehensive benefits including 401k
- •stipend for administrative duties

Please contact Diana McClure at 800-325-2716 or FAX your CV to 314-919-8920 for immediate consideration.

report, Dr. Deane L. Johnson for his advice and constructive comments, and the physicians and staff of St. Joseph's Hospital for their support.

Ann Sudoh is a first-year family practice resident in the Duluth Family Practice Residency Program. She helped treat the patient described in this case report while participating in the University of Minnesota Medical School's Rural Physician Associate Program (RPAP) in Park Rapids, Minnesota. RPAP is a nine-month elective that allows third-year medical students to experience rural medicine through one-on-one teaching, hands-on clinical experience, and problem-based learning.

REFERENCES

1. Bartlett J. Clostridium tetani. In: Gorbach SL, Bartlett JG, Blacklow MR, eds. Infectious diseases. Philadelphia: WB Saunders, 1992:1580-3.
2. Gergen PJ, McQuillan GM, Kiely M, Ezzati-Rice TM, Sutter RW, Virella G. A population based serological survey of immunity to tetanus in the United States. N Engl J Med 1995;332(12):761-6.
3. Abrutyn E. Tetanus. In: Isselbacher KJ, Braunwald E, Wilson DD, Martin JB, Fauci AS, Kasper DL, eds. Harrisons principles of internal medicine. 13th ed. New York: McGraw-Hill, 1994:633-5.
4. Groleau G. Tetanus. Emerg Med Clin North Am 1992;10(2):351-60.
5. Bleck TP. Tetanus: pathophysiology, management and prophylaxis. Dis Mon 1991;37(9):556-663.
6. Wright DK, Lalloo UG, Nayiager S, Grovender P. Autonomic nervous system dysfunction in severe tetanus: current perspectives. Crit Care Med 1989;17(4):371-5.
7. Sutton DN, Tremlett MR, Woodcock TE, Nielsen MS. Management of autonomic dysfunction in severe tetanus: the use of magnesium sulfate and clonidine. Intensive Care Med 1990;16:75-80.

University of Maryland

Managing Disaster

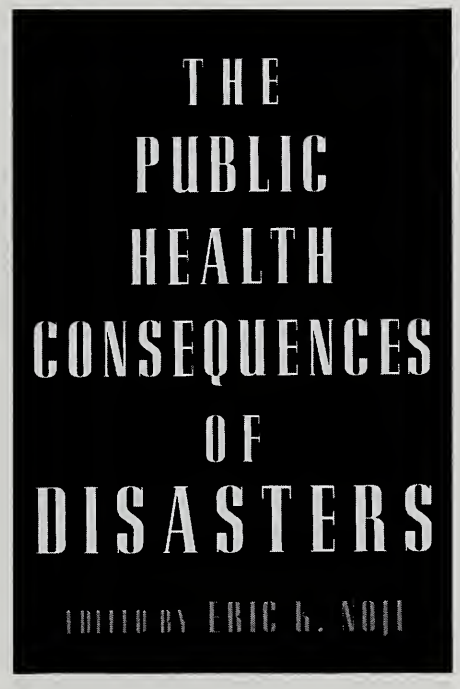
"The Public Health Consequences of Disasters" is an important reference tool for public health management during natural and human-made disasters.

Reviewed by James N. Logue, Ph.D., M.P.H.

To increase our awareness of the significant human losses associated with disasters throughout the world, the United Nations declared the 1990s the International Decade for Natural Disaster Reduction (IDNDR). As part of the response to the United Nations initiative, editor Eric K. Noji, M.D., with 15 other contributors, has developed a major reference text on public health and disasters.

"The Public Health Consequences of Disasters" (Oxford University Press, 1996) is a significant update to the 1989 monograph by the Centers for Disease Control and Prevention (CDC) on the same subject. As with the earlier monograph, many of the contributors have had extensive medical and public health experience related to recent disasters in both national and international settings while serving as physician-scientists or public health professionals within the CDC.

Following the approach used by Michael Gregg, M.D., who served as editor and contributing author of the 1989 CDC monograph and who provides the foreword to this text, Dr. Noji divides the 20-chapter book into four main sections: general issues, geophysical events, weather-related problems, and human-generated problems. While 15 of the chapters provide additional and more current information on topics previously covered, new chapters present timely and authoritative information on other important issues, such as environmental health, mental health, epidemiologic methods used to study disasters, and descriptions of acute situations affecting large civilian populations (complex emergencies).



The introduction and first two chapters, which cover the nature and general characteristics of disasters and the relatively new field of disaster epidemiology, are well-written by Dr. Noji and provide an excellent primer to the rest of the text. Noji indicates that the public health reviews throughout the text emphasize an epidemiologic approach and present a common theme: that the public consequences of disasters can be eliminated or greatly reduced by implementing effective prevention and control measures. I found that these stated objectives were definitely achieved. Readers will most certainly want to venture beyond the introductory sections, however, since the following chapters have something for everyone.

Having served as an environmental epidemiologist in a state health department for almost 15 years, I was particularly interested in learning more about the natural and human-made disasters that have occurred throughout the United States and their impact on human health. I was not disappointed. Many authors provide comprehensive reviews of major national disasters that frequently occur, such as floods, tornadoes, hurricanes, and earthquakes, and the associated mortality and morbidity patterns. They also provide important recommendations and practical advice, such as known health risk factors associated with specific disasters or available educational materials (for example, CDC pamphlets on specific disasters—see the sidebar). I was fascinated by the review on volcanoes by Peter Baxter, M.D., as I learned that there are numerous volcanoes in the western United States, Alaska, and Hawaii. Two volcanoes, Mauna Loa in Hawaii and Mount Rainier in Washington, are included on IDNDR's listing of "Decade Volcanoes," which require special study. The health threats associated with volcanoes are well-covered, with a special focus on lessons

First Call Physicians, Inc.
A Locum Tenens Service
500 Eighth Ave. S.
Buffalo, MN 55313

Clinics/Hospital | **Physicians**

Locums Coverage
=
Revenue

- Patients falling through the gaps?
- Physician burn-out or illness?
- Shortage of physicians?

- Earn more with less time.
- No administrative headaches.
- Malpractice premium paid.

Experience, Service, Honesty
Call (metro) 682-3852
(toll free) 888-682-3852

(You'll be glad you did!)

PHYSICIAN/CHIEF OF SURGERY

The Iron Mountain VA Medical Center, located in the beautiful Upper Peninsula of Michigan, is seeking a Physician BC/BE in ***Internal Medicine*** or ***Family Practice*** and a ***Chief of Surgery*** BC with endoscopic experience. Excellent benefit package includes competitive salary, malpractice protection, 30 days paid vacation, sick leave, Federal Employees Retirement System enhanced by a savings plan with matching contributions. Subject to pre-employment drug screening. An equal opportunity employer. Contact Charlene Nerone at (906) 774-3300, ext. 2281.

CDC Brochures Provide Information on Public Safety During Disasters

The Centers for Disease Control and Prevention (CDC) in Atlanta publishes brochures to promote personal health and safety during floods, hurricanes, earthquakes, and extreme cold and heat. The flood and hurricane brochures are available in Spanish, as well as English. The CDC also publishes a brochure entitled "Emergency Response Planning and Coordination," which describes the CDC's Emergency Response Coordination Group of the National Center for Environmental Health. All brochures are available free of charge to health care professionals by calling Barbara Snow at 770/488-7100.

learned from the 1980 Mount St. Helens eruption. For those with an interest in international health, several chapters, such as reviews by Michael Toole, M.D., on complex emergencies and Ray Yip, M.D., on famine, provide excellent insights into the devastating public health consequences associated with recent international disasters.

Although Dr. Noji states in the introduction that the book cannot cover all areas of emergency response and preparedness, I would have enjoyed seeing some review of terrorist emergencies (for example, the 1995 Oklahoma City bombing) and transportation disasters (such as airline crashes). The chapters by Edwin Kilbourne, M.D., on hot and cold environments give excellent practical examples of how normal seasonal events can result in significant public health emergencies. My one suggestion is that the chapter on cold environments be expanded in the future to include potential adverse effects related to blizzards and other snow emergencies. As I read Noji's chapter on earthquakes, I noted that entities considered under morbidity and mortality could also apply to non-earthquake emergencies, such as the collapse of buildings due to acts of terrorism. A major strength of the book, in fact, is the applicability of medical and public health information and recommendations from any given chapter to other areas.

Many physicians at the local level will find this book directly relevant to their practices. Specific chapters, particularly those on flooding, hurricanes, tornadoes, and hot and cold environments, will certainly increase practicing physicians' level of awareness of potential health threats for their patients due to normally recurring events in certain high-risk areas. For physicians, public health professionals, and all others who have an interest in the medical and public health implications, "The Public Health Consequences of Disasters" is an outstanding desk reference. I recommend it wholeheartedly and without reservation. It is a fascinating book that will serve as an authoritative source of information for many years to come. MM

James Logue is an environmental epidemiologist with the Pennsylvania Department of Health in Harrisburg.

Reprinted with permission from JAMA 1997;277(20):1649. ©1997 American Medical Association.

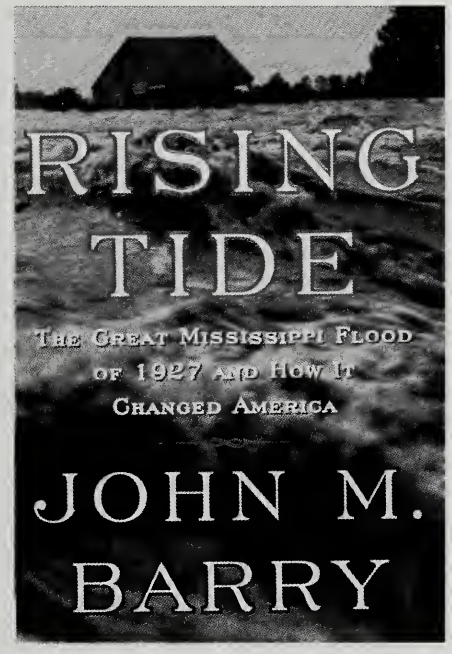
University of Maryland

The Power of Raging Waters

"Rising Tide: The Great Mississippi Flood of 1927 and How It Changed America," by John M. Barry, chronicles the social and political disruption left in the wake of a monster flood 70 years ago and offers perspective on the flood of 1997.

Reviewed by Charles R. Meyer, M.D.

Floods are more than meteorological events. They bring social chaos, political crises, and human tragedy. In Fargo and Grand Forks, we've seen devastated communities. We've watched Gov. Carlson and President Clinton come, marvel, and pledge. We've observed the panoply of personal loss. It's hard to believe it was ever worse. But it was. In 1927, a monster flood in the Mississippi River Valley roared through Mississippi and Louisiana, altering not only the face of the land, but also the metabolism of Southern politics. The flood also sent a ripple through national politics. John M. Barry's "Rising Tide: The Great Mississippi Flood of 1927 and How It Changed America" (Simon and Schuster, 1997), starts with engineers wrangling over the best technique to control the Mississippi and ends with politicians maneuvering to game the flood and advance their careers.



The statistics in Barry's book read like fiction: 120,000 people left homeless in Louisiana, 180,000 in Mississippi, 1 million nationwide. The heavy rains started in the fall of 1926; one Illinois town was flooded for 273 days. The Mounds Landing levee crevasse flooded an area 50 miles wide and 100 miles long with up to 20 feet of water. The flood covered houses 75 miles away and affected almost 1 percent of the nation's population.

The descriptions seem Biblical: "The flood water approached in the form of a tan-colored wall seven feet high, and with a roar of a mighty wind." "In the entire flooded region 50 percent of all animals—half of all the mules, horses, cattle, hogs, and chickens—had drowned. Thousands of tenant-farmer shacks had simply disappeared." Compared with this, Noah had it easy.

The tragedy resulted in a panorama of political, social, and engineering battles. The political power of Mississippian Leroy Percy—aristocrat, senator, scion of Greenville, Mississippi, and grandfather of novelist Walker Percy—was pitted against state and national foes. The federal government fought state and local powers. The fate of New Orleans clashed with the welfare of the territory upstream. Engineers James Buchanan Eads, designer of the bridge across the Mississippi at St. Louis, and Andrew Atkinson Humphrey, head of the Army Corps of Engineers, dueled over the proper techniques to control the mighty river. And always, there was the ever-present racial issue. Decisions about who was evacuated, who got assistance, and who worked on the levees revolved around race.

The flood's political overflow was extensive. Mississippi and Louisiana politics changed forever. Huey Long rode into power on the tide of dissatisfaction over the handling of the flood. Herbert Hoover, who headed the federal relief effort and emerged as a hero even though his creation of private-sector credit accomplished little, won the presidency in 1928. A 1928 law that earmarked $330 million for federal involvement in river management heralded a new expansion of federal control over local issues, a power that grew exponentially in the 1930s.

History may not clone itself, but it sure recreates familiar faces. As the Red River waters recede, squabbling over promised federal aid, tricky dancing by politicians, and social disruption echo the roar of the rising tide in Mississippi and Louisiana 70 years ago in this fascinating tale by John Barry. MM

Charles Meyer is editor-in-chief of Minnesota Medicine *and an internist with Consultants–Internal Medicine in Minneapolis.*

Look For This Seal





The 21st Century will usher in significant changes in the medical profession. To help physicians meet these challenges, the MMA and HMS founded Minnesota Medical Business Resources (MMBR—pronounced MeMBeR), a physician-owned corporation, dedicated to uncovering and meeting physicians' personal and professional needs.

The mission of Minnesota Medical Business Resources is to use its unique understanding of its market to discover, invest in, and be the premier broker of high value products and services that improve the operation of medical groups, and the personal and professional lives of individuals in the health care system.

MMBR achieves its mission by asking physicians and clinics about their needs, then designing and delivering products or services that meet those needs in the most cost-effective manner, while focusing on quality service.

To be certain you are getting the best product and service of its type, MMBR has created this seal. This seal is your assurance that the product or service offere meets a specific set of standards for quality and value, and has survived the scrutiny of your peers.

Look for the seal the next time you need insurance, consulting services, a new car, cellular communications services and products, travel assistance, and more. Put your trust in MMBR.. physicians working for physician

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES
OWNED BY
MMA & HMS

People and Places Making Medical News

People

State BMP President Elected to National Board

Doris Brooker, M.D., an associate professor and senior physician at the University of Minnesota and president of the Minnesota Board of Medical Practice, was elected to the board of directors of the Federation of State Medical Boards. The federation makes recommendations on national policies for regulating medical professionals and provides support to state licensing boards.

Allina President to Chair Healthcare Forum Board

Allina Health System President **James Ehlen, M.D.**, has been appointed chair-elect of the Healthcare Forum board of directors. The San Francisco-based Healthcare Forum works to create new visions and models of health care. The organization has championed the Healthier Communities movement and developed tools for health systems to improve quality, respond to market changes, and contribute to community health.

"This is a critical time for American health care," said Ehlen. "It is also an important time for Allina and other organizations focused on healthier communities to share on the national level ideas and lessons learned in our own arena."

'U' Awards Outstanding Pediatricians

The Department of Pediatrics at the University of Minnesota recognized outstanding pediatric achievement by residents, fellows, faculty, and community pediatricians at a banquet June 18. **Don Amren, M.D.**, and **Paul Singh, M.D.**, received the department's highest level of recognition, the Gold-Headed Cane Awards, for lifetime achievement. Also receiving awards were **Elizabeth Ingulli, Jamie Lohr, Julie Ross, Jeanne Mrozek, Carol Yeh, Matthew Segedy, Ex Guiang, Youngki Kim, Sarah Jane Schwarzenberg, Michael Sweeney, Richard Andersen, Marjorie Hogan, Jeffrey Lobas, James McCord, Kenneth Tegtmeger**, and **Michael Severson.**

Places

HealthSystem Minnesota Commits to Technology Overhaul

St. Louis Park-based HealthSystem Minnesota has launched a three-year plan to replace its computer and telecommunications equipment with cutting-edge, integrated technology that will link and automate 30 facilities. The plan is expected to cost nearly $70 million but to save money in the long run.

HealthSystem's new network combines computer and phone communications, which will allow the hospital system to handle both standard phone calls and detailed medical records with the same phone lines. HealthSystem also plans to install new client/server computers to replace its mainframes. An intranet will allow employees to access electronic patient records and other information easily and quickly through Web browser software familiar to Internet users.

HealthSystem is one of the first hospital systems in the country to invest in the new technology. The move is part of an ongoing effort to integrate Methodist Hospital and Park Nicollet Medical Center, which merged four years ago to form the 6,000-employee HealthSystem Minnesota.

Medtronic Coronary Stent Receives FDA Approval

Fridley-based Medtronic Inc. received FDA approval to begin selling its coronary stent in the United States. The new stent will be the first competition for Johnson & Johnson, which has a near-monopoly on the stent business. Industry observers expect Johnson & Johnson, based in New Brunswick, New Jersey, to charge Medtronic with patent infringement, but no suit has been filed. Medtronic's stent, shaped like a wire coil, is more flexible than current mesh wire tubes and easier for surgeons to use.

Medtronic's stent marks the company's first commercial entry into vascular devices. Until now, Medtronic's only vascular products were catheters, but the company is developing other devices for blood vessels. Other companies are expected to enter the stent market within a year; it is not clear how Johnson & Johnson's patent claims will affect the market.

HealthPartners Anti-Smoking Campaign Wins Award

HealthPartners received the 1997 Community Leadership Award from the American Association of Health Plans (AAHP) for a teen anti-smoking campaign. The AAHP is a national organization representing more than 1,000 HMOs, PPOs, and similar health plans. The Community Leadership Award is presented annually to the health plan that has contributed most to enriching the quality of life in the community it serves. **George Halvorson**, HealthPartners president and CEO, accepted the award at the AAHP annual conference in June.

The AAHP recognized HealthPartners for its aggressive anti-smoking campaign that includes



"My wife and I both practice here - it's a great place both professionally and aesthetically."
Ian Cunningham, M.D.

WASHINGTON

The Wenatchee Valley Clinic, a prominent 140+ physician, multi-specialty group practice in the Pacific Northwest has several practice opportunities throughout its practice locations. **Currently, we are seeking:**

WENATCHEE
- **Gastroenterologist**
- **Cardiologist**
- **Infectious Disease**
- **Physiatrist**
- **Pulmonary**

OMAK/MOSES LAKE
- **Family Practice w/OB**
- **Obstetrician**
- **Ophthalmologist**
- **Urgent Care**
- **Dermatologist**
- **General Internist**
- **Gastroenterologist**
- **Radiologist**
- **Nephrologist/I.M.**
- **Pediatrician**

All positions offer an excellent compensation and benefit package. North Central Washington provides a high quality of life for those interested in an abundance of recreational opportunities in a family-oriented rural setting.

Please send CV to James Brown, M.D. -
P.O. Box 489
Wenatchee, WA 98807
FAX (509) 664-7178
Wenatchee Valley Clinic
see our home page @ http://www.wvc.com

Weigh The Facts!

Benefits to clinics, hospitals and practitioners include:
-Large pool of seasoned physicians.
-Integral part of medical referral network.
-Current in medical care policies, procedures and protocol.

To physicians of all specialties:
-Confidentiality prioritized.
-Financial incentives.
-Medical malpractice.
-Personalized service tailored to your needs.



Whitesell
Medical Locums, Ltd.

Eight First Avenue South
Buffalo, MN 55313
1(800) 876-7171
1(800) 295-6373
***Local* 682-5218 or 682-5906**
FAX (612) 682-4791

MTV-style television commercials, radio ads, billboards, and events designed to show teens that smoking isn't cool.

Medica Receives CDC Grant for Fitness Pilot Project

Medica Health Plans, part of Allina Health System, received a $25,000 grant for a pilot promotion of physical activity and nutrition as part of a national effort funded by the Centers for Disease Control and Prevention and the American Association of Health Plans. The three-month program will help people increase their physical activity and improve their eating patterns. Medica will offer the services to about 2,400 employees from the *Star Tribune* in Minneapolis and Computype in St. Paul.

The CDC and AAHP project is providing a total of $100,000 to four health plans across the country to promote exercise and healthy eating habits.

Socioeconomics

HMOs Raise Premiums, Tell Physicians to Cut Costs

Citing rising costs and declining profits, Minnesota's largest managed care organizations will increase health insurance premiums 5 percent to 15 percent this fall. HealthPartners, Blue Cross and Blue Shield of Minnesota, and Medica say that consumers will have to pay more. Health care premiums jumped 3 percent to 5 percent across the nation last year, but Minnesota's prices remained stable.

Medica also warned its physicians that they could lose up to 10 percent of their fees if they did not find ways to cut costs. In a letter to more than 6,000 physicians, Medica told them to reduce the use of some of the most expensive treatments, such as CAT scans, MRIs, and certain prescription drugs, including antidepressants.

Medica's letter followed a move two weeks earlier by Blue Cross and Blue Shield of Minnesota to reduce the fees it pays to some specialty physicians by 10 percent to save about $3 million of the $525 million it spends on health services annually.

Managed care organizations in the state say they are being squeezed by costs that are rising faster than premiums. All of the state's health plans reported operating losses in 1996. "In the last couple of years, Minnesota's HMOs—and Medica in particular—tried to expand their market share by pricing their products at a rate that was not adequate to cover the cost of claims," said **Alan Baumgarten,** author of "Minnesota Managed Care Review," an annual report analyzing industry trends, in a *St. Paul Pioneer Press* article.

George Halvorson, CEO of HealthPartners, said the increased costs are not due to doctors' fees, which have been "negotiated down to the bone." Industry observers attribute most of the increase to a jump in the cost of prescription drugs.

Medica and Minnesota Specialty Physicians Form Alliance

Medica Health Plans and Minnesota Specialty Physicians, Inc. (MSP), the Twin Cities area's largest coalition of specialty care clinics, signed a five-year agreement that will help the two organizations control costs and improve service. **Tim Signorelli,** chief executive of the physicians' group, said MSP wanted to form an alliance with a health plan that would guarantee access to patients and provide a predictable, open understanding of reimbursement issues. He said the groups expect to save costs by eliminating administrative redundancies between the two organizations, creating new reimbursement methods, and using clinical research to become more efficient. The agreement allows both groups to remain independent and autonomous.

State Epidemiologist Threatens to Quit over Stagnant Pay

State epidemiologist Michael Osterholm, Ph.D., announced in July that he would quit his job at the Minnesota Department of Health at the end of August unless the Legislature passes an executive pay bill in a special session. State department heads have not received a pay increase for 12 years.

Under the state's compensation system, commissioners' salaries set the ceiling for their departments. Health Commissioner Anne Barry earns $67,500 a year, more than $30,000 below the national mean salary for health commissioners. Because of the salary cap, Osterholm said, his colleagues in the Health Department are underpaid. Osterholm, who is exempt from the salary cap, earns $96,000 a year and would not benefit from the pay hike bill.

"Much of our state's vital public health structure is threatened," he said at a July news conference. "As a matter of principle, I no longer can remain silent on this issue."

In Home Health Closes Some Facilities

In Home Health, a Minnetonka-based home health care provider, will lay off about 50 employees and close several facilities in an effort to improve profitability. The company will not drop any of the 10 markets it serves, although it will close half of its 12 pharmacies. The company has struggled, mainly because profit margins are very tight with Medicare patients, who account for about 70 percent of In Home Health's business.

Rates, Trends, Data

Number of People with AIDS Hits 1.64 Million

The number of people with AIDS has reached 1.64 million and is growing at nearly 20 percent a year, according to the World Health Organization. The U.N. agency estimates that the reported AIDS cases are only 20 percent of the actual number. The United States accounted for 581,429 cases and Canada had 14,836. Africa has recorded 576,972 cases and Asia 70,949.

Law & Policy

Hemophiliacs Win Settlement with Pharmaceutical Companies

Some hemophilia patients who contracted HIV through blood products will receive $100,000 in a settlement with pharmaceutical companies. The settlement, resulting from a class-action suit, allows patients or their survivors to receive the money. Some 110 Minnesotans are eligible for the checks, which were mailed in July. The companies involved in the settlement are Baxter Healthcare Corp., Armor Pharmaceutical/ Rhone-Poulenc-Rorer, Alpha Therapeutic Corp., and Bayer Corp.



MINNEAPOLIS HEART INSTITUTE FOUNDATION

with St. George's Hospital Medical School (London) present an

International Summit on Diagnosis & Management of Hypertrophic Cardiomyopathy, Sudden Death & Athletes

October 15-17, 1997 • Minneapolis, Minnesota
Course Director: Barry J. Maron, M.D. • Co-Director: William J. McKenna, M.D.

This International Summit on Diagnosis and Management of Hypertrophic Cardiomyopathy, Sudden Death, and Athletes is a unique, 2½ day symposium designed for those interested in a broad but in-depth survey of the topics of youthful sudden death and hypertrophic cardiomyopathy, as well as issues relevant to the risks of the athletic field. The program includes 24 internationally recognized and distinguished experts participating in lectures, panels, and informal discussions.

Faculty: Martin M. Borggrefe MD• Robert M. Campbell MD• Franco Cecchi MD• Gordon K. Danielson MD• Yoshinori L. Doi MD• Perry M. Elliott MD• Philip R. Fox DVM• Michael P. Frenneaux MD• Robert A. Kloner MD• Harry M. Lever MD• Robert A. Levine MD• A. J. Marian MD• Barry J. Maron MD• William J. McKenna MD• Matthew J. Mitten JD• Rick A. Nishimura MD• Nicolas Sadoul MD• Christine E. Seidman MD• Ulrich Sigwart MD• Paolo Spirito MD• Gaetano Thiene MD• Paul D. Thompson MD• Jeffrey A. Towbin MD• E. Douglas Wigle MD

Visit our website for complete program information: www.mplsheartfoundation.org
Minneapolis Heart Foundation, 920 E. 28th Street, Ste. 160, Mpls, MN 55407 (612) 863-1657.

Acupuncturists Now Need License to Practice

Starting in July, acupuncturists in Minnesota needed a license to practice, because of a law passed two years ago. The law allows acupuncturists to join physicians, dentists, and chiropractors as licensed health care providers and signals acupuncture's growing acceptance in mainstream medicine.

To be licensed, acupuncturists must pass a national exam and a state "clean needle" technique exam, continue to upgrade their education, and meet the same financial and ethical standards that physicians obey. The Minnesota Board of Medical Practice will oversee acupuncturists.

"One of the most important things this law ensures is the safe, competent practice of acupuncture for all Minnesotans," said **Michael Studer**, president of the Acupuncture Association of Minnesota, in a *St. Paul Pioneer Press* article.

HealthPartners and Allina cover the cost of acupuncture treatment recommended by patients' physicians. Blue Cross and Blue Shield reimburses for acupuncture treatment for chronic pain in a hospital-based program.

Medical Research

Mayo Clinic Finds Fen-Phen May Damage Heart Valves

Researchers at the Mayo Clinic identified 24 previously healthy women who developed heart valve damage after taking the popular diet drug combination fen-phen (fenfluramine and phentermine). Mayo physicians and the U.S. Food and Drug Administration warned physicians and patients that the drug combination might damage heart valves and cause potentially fatal pulmonary hypertension.

"We have not established a cause and effect relationship," said **Heidi Connolly, M.D.**, a Mayo cardiologist. "We have shown an association."

Physicians discovered the valve problems in the women during routine office visits. The patients had suspicious heart murmurs or hypertension, shortness of breath, swollen ankles, and fatigue. Five of the women had open-heart surgery to repair or replace their defective valves. Eight women developed pulmonary hypertension.

A lawsuit filed the day after the Mayo Clinic issued the warning accused the drugs' manufacturers, Wyeth-Ayerst Laboratories Inc. and SmithKline Beecham, of concealing the drugs' risks.

Study: Magnetic Fields Do Not Increase Leukemia Risk

A study by the National Cancer Institute and the Children's Cancer Group indicates that electromagnetic fields in the home do not increase risk for leukemia in children. University of Minnesota Cancer Center researcher **Leslie Robison, Ph.D.**, professor of pediatrics, was co-investigator of the study, published in the July 3 *New England Journal of Medicine*.

In the largest and most geographically diverse study of its kind, the researchers found that children who lived in homes with high measured magnetic fields were not significantly more likely to be diagnosed with acute lymphoblastic leukemia (ALL) than children living in homes with lower magnetic field levels. Nor was ALL found to be more likely among those in homes classified in high "wire-code" categories, a surrogate measure of magnetic fields based on location and the type of, and distance to, external power lines.

"We found no evidence that power lines had any association with the risk of childhood leukemia in the nine states we studied," Robison told the Minneapolis *StarTribune*.

Fears of a connection between power lines and childhood leukemia surfaced in 1979, when Denver researchers concluded they found a link; other small studies since then have also indicated an association.

The NCI/CCG researchers are analyzing the children's electrical appliance use and will report on these results in 1998.

Longer Needles Needed for Immunizations

Longer needles are needed to ensure that immunizations are effective in many people, conclude Mayo Clinic vaccine researchers in a study published in the June 4 *Journal of the American Medical Association*. Many vaccines are meant to be injected into the deltoid muscle. But ultrasound studies of the amount of deltoid fat on 220 people revealed that the standard 5/8-inch needle used for immunizations would not have reached the muscle in 48 percent of the women and 17 percent of men. The study concludes that 1- to 1.5-inch needles are needed for heavier people. Injecting vaccines into fat instead of muscle results in more vaccine failures and also is more painful, since fat has more nerve fibers than muscle. MM

OFFICE PRODUCTS AT PRICES THAT WILL MAKE YOU *gasp*

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED



We all need office supplies. The key is to find the vendor that carries everything you need at the best possible prices. MMBR has selected Office Depot as our endorsed office supply vendor. Through MMBR, you can save an average of *40 percent off* all general office supplies and furniture. MMBR has also arranged retail store pricing on *electronics, business machines, and software,* a special *Purchasing Card* to take advantage of volume discounts at 7 Twin Cities retail stores, and additional *frequent buyer discounts.* Ask about our *convenient billing options.* MMBR can put the immediate response of *Internet* and specialized software ordering at your fingertips, and *next day delivery* is standard with nearly all products. For personal attention and unparalleled service, call 623-2860, or toll free 800-298-MMBR (6627), and ask for our office supply program.

MMBR

OFFICE SUPPLY

MINNESOTA MEDICAL BUSINESS RESOURCES
OWNED BY MMA & HMS

The Right Prescription for Long Term Care Insurance

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED

The ABC's of Long Term Care Insurance: the physician as the ***Advisor*** to their patients, a potential ***Buyer*** of the product, and in many cases the designated ***Caretaker*** within their own family. The Minnesota Medical Association recognizes your request for education, information, and service on this topic and MMBR has developed a program to help you answer the questions being asked by your patients and your parents! It also lets members, spouses, parents, and parents-in-law purchase this type of coverage for up to ***20% off standard rates!***

For information on the MMA program, a schedule of educational workshops, or a private consultation for you or your family members, call MMBR at ***612-623-2860 or 800-298-6627.***

ROBERT K. SMITH, M.D.
2424 Main Street East
Anytown, MN 55505
(612) 555-1212

NAME _____

ADDRESS _____

℞

MMBR

INSURANCE SERVICES
MINNESOTA MEDICAL BUSINESS RESOURCES
OWNED BY MMA & HMS

TravelersInsurance
A Member of TravelersGroup

MMA
MINNESOTA MEDICAL ASSOCIATION
MEDICINE'S VOICE IN MINNESOTA

This plan is administered for the members of the Minnesota Medical Association by:

Newman Financial Services

NFS

Noble War

continued from page 13

to do, but most did not complain. Our worst near-disaster occurred when more than a dozen people were overcome by carbon monoxide after a downtown business tried to pump water from its basement with gas-powered pumps.

The medical facilities in Granite Falls fared very well. The main parts of our hospital and nursing home are on the second floor and were never threatened. The medical clinic is on the ground floor but was not flooded. We did suspend all clinic operations for four days and removed or elevated vital parts of the clinic, such as computers, patient records, and equipment. On April 6, Highway 212 north and Highway 23 south were cut off by the river, preventing many hospital personnel from either coming to work or getting home. An airplane ferried nurses across the river so they could spell crews that had been working for several days.



PHOTOGRAPH ©GRANITE FALLS-CLARKFIELD ADVOCATE-TRIBUNE

City crews discovered another use for a snowblower—removing water from the top of a dike.

Recovery Begins as Waters Recede

When the river finally crested, on April 7, it reached a level five feet higher than ever recorded in Granite Falls. The community's infrastructure was saved, including the sewage system. But every war brings casualties. Some people's property had to be sacrificed to save the majority of the community. The basements of most downtown businesses flooded, and owners lost hundreds of thousands of dollars' worth of merchandise. Our 98-year-old Granite Falls United Church of Christ suffered structural damage.

After the waters receded, the hardest part of the flood began. Everyone was physically and mentally exhausted. The floodwaters left a smelly, dirty mess. Cleaning up flooded basements and removing truckloads of destroyed personal treasures led to feelings of loss and defeat. Most families had to "gut" their houses and throw away almost everything—floor coverings, wall coverings, sheetrock, insulation, furnaces, and air conditioners. Some people lost irreplaceable family treasures. The Salvation Army assisted businesses and families by bringing in volunteers to help clean out the dirt, remove damaged walls, floors, and furnishings, and wash the remaining walls or bare studs.

The war against the 1997 flood in Granite Falls is over, but the healing and reconstruction have just begun. The adrenaline rush of fighting the flood has been replaced by the grief and depression that settle in as the reality of regrouping, reorganizing, and rebuilding must be faced. Healing after a loss tends to be done mostly alone and requires a lot of time. Nevertheless, none of us will ever forget the teamwork and mutual concern that saved our community and will help us rebuild. We can never repay the many gifts offered: work, equipment, food, and kindness. We can only say thank you and feel grateful we saved as much as we did. **MM**

Brothers Kenneth Carter and Darrell Carter are family physicians with Affiliated Community Medical Centers in Granite Falls.

---

*After about a week, a State Board of Health nurse showed up to tell the Deluge Diner that the home-prepared foods did not meet health codes, but by then the river was falling and food companies had donated plenty of provisions.

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

AUGUST 1997

Aug. 9 **Advanced Phacoemulsification Techniques** Phillips Eye Institute; Minneapolis, MN. CONTACT: Leslie Gibson, Phillips Eye Institute, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061; fax 612/870-0315; E-mail gibson@allina.com.

Aug. 10-12 **Success with Failure: Evaluation and Treatment of Congestive Heart Failure** Mayo Foundation; Vail Cascade Hotel and Club, Vail, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Aug. 15-16 **Optimizing Disease Management Through Pulmonary and Gas Exchange Diagnostics** University of Minnesota Continuing Medical Education; Sheraton Washington Hotel, Washington, D.C. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Aug. 15-16 **Statistical Computing** Hennepin County Medical Center; Cragun's Resort, Brainerd, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Aug. 21-23 **Medical Directors Training Program** University of Minnesota Continuing Medical Education; The Historic Brown Palace Hotel, Denver, CO. CONTACT: Registrar, Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

SEPTEMBER 1997

Sept. 5-6 **Orthotics and Prosthetic Symposium: A Multidisciplinary Approach to Orthotic and Prosthetic Management** Mayo Foundation; Siebens Medical Education Building, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 8 **Ettinger Lecture (Neurology)** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 8-11 **Counseling the Compulsive Gambler: Phase II** Minnesota Council on Compulsive Gambling; New Orleans, LA. CONTACT: Elizabeth M. George, 314 West Superior Street, Suite 702, Duluth, MN 55802; 218/722-1503.

Sept. 12-13 **Advanced Trauma Life Support Course** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Sept. 12-14 **Annual Ambulance Medical Directors Retreat** Hennepin County Medical Center; Radisson Arrowwood, Alexandria, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 800/263-4262.

Sept. 19 **Contemporary Issues in Hemodialysis** Hennepin County Medical Center; Sheraton Midway Hotel, St. Paul, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 19 **Second Annual Regional Ob/Gyn Conference** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

University of Maryland

Sept. 19-20 **Mayo Clinic Update in Hepatology and Liver Transplantation 1997** Mayo Foundation; Minneapolis Hilton and Towers, Minneapolis, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 19-20 **Midwest Glaucoma Symposium** Phillips Eye Institute; Marriott City Center, Minneapolis, MN. CONTACT: Leslie Gibson, Phillips Eye Institute, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061; fax 612/870-0315; E-mail gibson@allina.com

Sept. 19-20 **Through the Eyes of Others: Envisioning Culturally Competent Healthcare** Hennepin County Medical Center; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 21-23 **Echocardiography for the Sonographer 1997: Focus on Valvular and Myocardial Disease** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 21-25 **Advances in Diagnostic Radiology** Mayo Foundation; The Empress Hotel, Victoria, British Columbia. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 24-26 **Advanced Radiology Life Support Course** Mayo Foundation; The Empress Hotel, Victoria, British Columbia. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 25-26 **24th Mayo Clinic Pediatric Days** Mayo Foundation; Leighton Auditorium, Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 26-27 **Statistical Computing** Hennepin County Medical Center; Brainerd, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 26-28 **The 1997 Interim Meeting of the Society for Pediatric Pathology** Society for Pediatric Pathology; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Cathy Vaidich, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/813-6711.

OCTOBER 1997

Oct. 2-3 **Annual Forensic Science Seminar** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

NEW ULM MEDICAL CENTER
ALLINA HEALTH SYSTEM

This facility is located in the beautiful south central Minnesota town of New Ulm. Currently we are looking for quality physicians in these specialties:

- **OB/GYN**
- **Psychiatry**
- **Family Practice**
- **Internal Medicine**
- **Orthopedic Surgery**

We enjoy the finest in facilities (our clinic is attached to the hospital with an emergency room) and the latest in technology. You can have the autonomy of a private practice, plus have the security of a highly respected health care system. Practicing with us, you will have an opportunity to make a difference, not only for your patients, but for the medical profession itself as well.

For Additional Information Contact Either:

Les Stern
Allina Health System
Route 80775
5601 Smetana Drive
Minnetonka, MN 55434
(612) 992-3078 or (800) 248-4921
Fax: (612) 992-3669

Daniel Groebner, M.D., M.S.
Director of Medical Affairs, Internal Medicine & Administrative Medicine
P.O.Box 577, 1342 N.5th St.
New Ulm, MN 56073
(507) 354-0448
Fax: (507) 359-1435

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142

E-Mail: stephanie.l.jussila@qm.healthpartners.com

Central Minnesota Group Health Plan
HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220

Oct. 2-3 **Meeting the Challenges of Rural Cancer Care** St. Mary's/Duluth Clinic Health System; Duluth, MN. CONTACT: Mary Connolly, Educational Services, St. Mary's/Duluth Clinic, 400 East Third Street, Duluth, MN 55805; 218/726-4434 or fax 218/726-4273.

Oct. 2-3 **Research Statistics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 9-10 **Annual Orthopedic and Trauma Seminar** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 9-10 **Clinical Research Methods** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 10 **Sixth Annual Conference for CME Planners** Minnesota Medical Association; Northland Inn, Brooklyn Park, MN. CONTACT: Jane Phillip, MMA, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/342-5662.

Oct. 15 **Domestic Violence Conference** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 16 **Medical Staff Meetings** Hennepin County Medical Center; Whitney Hotel, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 16-19 **American Society of Addiction Medicine's 10th National Conference on Nicotine Dependence** American Society of Addiction Medicine; Minneapolis Marriott City Center, Minneapolis, MN. CONTACT: Sandy Metcalfe, 4601 North Park Avenue, Chevy Chase, MD 20815; 301/656-3920.

Oct. 24-25 **Psychiatry in Practice: Honoring Tradition, Incorporating Innovation** Mayo Foundation; Siebens Building, Mayo Clinic Campus, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 30 **Geriatric Update for the Primary Care Physician** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

NOVEMBER 1997

Nov. 14-15 **Laboratory Diagnosis of Fungal Infections** Mayo Medical Laboratories; The Founders Inn and Conference Center, Virginia Beach, VA. CONTACT: Julie McAdams, 200 First Street SW, Rochester, MN 55905; 507/284-8599.

Nov. 21-22 **Osteoporosis Conference** Hennepin County Medical Center; Doubletree Grand Hotel, Bloomington, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

FEBRUARY 1998

Feb. 27-Mar. 1 **Current Concepts of Erectile Dysfunction: Diagnosis and Treatment** Mayo Foundation; Caribe Royale Resort Suites, Lake Buena Vista, FL. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Minnesota Medicine
AN EXCELLENT ADVERTISING INVESTMENT

Target marketing pays real dividends with your space advertising in *Minnesota Medicine,* the official journal of the Minnesota Medical Association.

Delivered directly to offices, hospitals, and clinics, *Minnesota Medicine* reaches your key clients and prospects in their business setting.

For complete advertising information contact:

Sherry Makela
Minnesota Medicine
3433 Broadway Street NE, Suite 300
Minneapolis, Minnesota 55413
612/378-1875
800/DIAL-MMA

University of Maryland

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., August 15 for October ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

Olmsted Medical Center is seeking BC/BE physicians in family medicine. Great opportunity for well-trained physicians to join a 75-physician multispecialty group in a dynamic, progressive practice. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes 10 branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (*5/96-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Part-time Neurologist wanted for multidisciplinary office. No call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Urgent Care Physicians: We are a growing urgent care practice looking for BC/BE physicians to work full or part time to staff our four clinics. We currently have three locations in the metro area and one location in Mankato and are planning on expanding in 1997. Please contact Cara Auge at 612/593-9818 or 800/511-2820 for more information on joining our growing practice, or send inquiries to 9800 Shelard Parkway, #210, Plymouth, MN 55441. (4/97-R)

Family Practice: Ob/gyn BC/BE to join progressive 33-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographic referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Scott D. Ellingson, M.D., or Janet M. Bergeron, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AOA/EOE. *3-10/97

An Exceptional Opportunity exists for a board-certified psychiatrist to be the associate chief of psychiatry for the newly integrated Mental Health and Behavioral Sciences Services between Minneapolis/St. Cloud Veterans Affairs Medical Centers. Incumbent will be stationed at St. Cloud, Minnesota, which is 65 miles northwest of the Twin Cities of Minneapolis and St. Paul, and will serve as the medical director for Mental Health and Behavioral Sciences. Incumbent will receive an academic appointment with the University of Minnesota Medical School at the appropriate level. Research and teaching opportunities are available. We are looking for an individual who has leadership experience and an interest in research. Candidates may apply by sending their CV to Patricia Barth, Personnel Management Specialist, VA Medical Center, 4801 Eighth Street North, St. Cloud, MN 56303. You may call the following persons to discuss the assignment: Dr. James Lukach, Chief of Staff, VA Medical Center, St. Cloud, MN, at 320/255-6317 or Dr. Joseph Westermeyer, Chief of Psychiatry, VA Medical Center, Minneapolis, MN, at 612/725-2000 ext. 3997. 1-8/97

Affiliated
COMMUNITY
Medical Centers, P.A.

Join the security of a large multispecialty group located in Southwest and West Central Minnesota Communities of 3,700 to 19,000. All areas flourish with four-season recreational opportunities, strong economies and excellent education where family and lifestyle are a priority. Outstanding benefits for BE/BC physicians in:

Dermatology	Neurology
Family Practice	Ob-Gyn
Internal Medicine	Orthopedic Surgery

Contact: Janiece Durham
Physician Recruitment Coordinator
Affiliated Community Medical Centers
101 Willmar Avenue SW
Willmar, Minnesota 56201-3591
320-231-6366

Opportunities Abound in America's Heartland: Exceptional practice opportunities available throughout the Midwest, from central Michigan to southern Missouri to lakeshore communities in eastern Wisconsin. We currently represent hospitals and clinics in the Midwest seeking physicians in a variety of primary care, surgical specialties, and subspecialties. Opportunities range from prominent multisite clinics to staff-model HMO to small-town practices. Whether you prefer a metropolitan/suburban city, scenic college town, restful resort community, or something inbetween, we have the setting for you. For more information, please call 800/243-4353, or forward your CV to: Strelcheck & Associates, Inc., 1009 West Glen Oaks Lane, Mequon, WI 53092. 1-8/97

Green Bay, Wisconsin–Prevea Clinic: An 80-plus physician-owned, multispecialty clinic is expanding its internal medicine department to meet growing patient base in a 200,000 community with a strong work ethic located in beautiful northeastern Wisconsin. 1:8 call. Contact Karen Van Gemert, 800/236-3030, or fax CV to 414/431-3043. Not a J-1 opportunity. *3-8/97

ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 32-physician multispecialty group currently recruiting additional physicians in the following specialties:
- DERMATOLOGY
- PEDIATRICS
- INTERNAL MEDICINE

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

FAMILY PRACTITIONERS: ARE YOU LOOKING FOR...

A CHALLENGING CLINICAL PRACTICE?
- Join 3 F.P. and 2 N.P. in a clinic with 25,000 annual patient visits
- Financially stable 31-bed hospital, 74-bed LTC, and HH agency
- Access to 26 outreach specialists
- Including Operative, Obstetric and Emergency Services

A GOOD LIFE?
- Working flexible 4.5 day week with 1:4 weekend and night call
- A progressively diverse rural community
- Within two hours of Fargo and Sioux Falls and three hours of Twin Cities
- Recreation: Big Stone Lake, 18-hole golf course, National Wildlife Refuge

A SUPPORTIVE COMMUNITY?
- Community-based Health Care Foundation with $1 million dollars pledged
- Providing competitive package including:
  - Guaranteed starting salary w/incentive
  - Two year housing allowance
  - Educational loan repayments

C.V. in confidence to Administrator
Ortonville Area Health Services,
Ortonville, MN 56278
Phone: (320)839-2502; FAX: (320)839-2507. EOE.

University of Maryland

Neurologist, Oncologist, Urgent Care

There are immediate openings at Brainerd Medical Center for a Neurologist, an Oncologist, and an Urgent Care physician.

Brainerd Medical Center, P.A.

- 35-Physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162 bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota

- Surrounded by the premier lakes of Minnesota
- Located in central Minnesota less than 2 ½ hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:

- Curt Nielson
  (218) 828-7105
  or (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

Wilderness Charm and Cosmopolitan Amenities

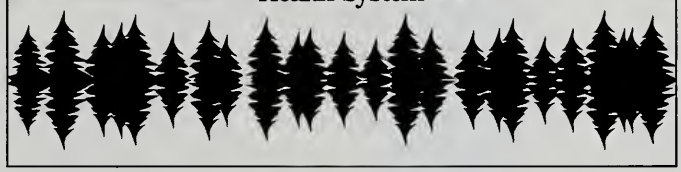
St. Mary's/Duluth Clinic Health System, a 300-physician multi-specialty group, with 3 hospitals and 22 neighborhood & regional centers serving a referral population of 460,000, seeks physicians in the following areas:

EP Cardiology	**Orthopedic Surgery**
Dermatology	**Ophthalmology-Retina**
Emergency Medicine	**Pathology**
Family Practice	**Pediatrics**
Internal Medicine	**Psychiatry – Adult**
Nephrology	**Psychiatry – Child**
Neurosurgery	**Rheumatology**

We offer a complete compensation package, including excellent fringe benefits and generous vacation/CME time. Only here can you listen to a duet of loons and a symphony orchestra in the same evening.

Contact Mike Griffin Marci Jackson or Jocelyn Heid, SMDC, 400 E. 3rd St., #500, Duluth, MN 55805 or call 1-800-342-1388 or fax 218-722-9952 or e-mail to: sr@smdc.org

SMDC
St. Mary's/Duluth Clinic Health System *eoe*



HealthPartners®
St. Paul-Ramsey Medical Center

CME
640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

Continuing Medical Education
1997 Fall/Winter Conference Schedule

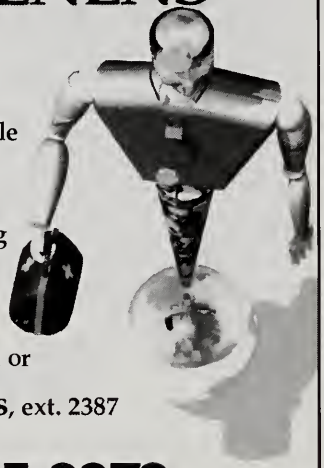
1st Annual Env. Health Policy Institute	September 8-19
15th Annual Occ. Health & Safety Institute	September 8-19
Infectious Diseases	November 7
Workers' Compensation	November 10-11
Strategies in Primary Care	November 13-15
Changing General Surgical Practices	November 13-14
Cardiovascular Medicine	December 4-5
Pediatric Orthopaedic Update	December 5

Information and Registration:
Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612-221-3992 • Fax 612-292-4773
St. Paul-Ramsey Medical Center/Ramsey Clinic/Ramsey Foundation are Members of the HealthPartners Family of Health Care Organizations

Staff Care, Inc.

"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS



- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging

Ask for :

John Moberly, ext. 2381 or

Melanie McReynolds, ext. 2387

(800) 685-2272

http://www.locumsnet.com

Staff Care is proud to sponsor *the Country Doctor of the Year Award*

Unable to place J-1 or H-1 physicians

AUGUST 1997 INDEX TO ADVERTISERS

Affiliated Community Medical Centers 62
Albert Lea Clinic 32
Alexandria Clinic, P.A. 62
Allina Health System 5, 24. 32, 59
Aspen Medical Group 46
Bone, Muscle & Joint, Inc. 5
Brainerd Medical Center 63
Central Minnesota Group Health Plan 59
Chisago Health Services 19
Fairview Clinic Services 31
First Call Physicians, Inc. 48
Gillette Children's Specialty Healthcare 3
HealthPartners 5
Hennepin Medical Society 3
Medical Protective Company ..... Cover 2
Midwest Medical Insurance Co. 11
Minneapolis Heart Institute–Allina 53
MMBR ..... Cover 4, 41, 50, 55, 56
Multicare Associates of the Twin Cities 46
North Memorial Medical Programs 10
Ortonville Area Health Services 62
PMIC, Inc. 28
Spectrum Emergency Care 46
St. Mary's/Duluth Clinic Health System 63
St. Paul-Ramsey CME 63
Staff Care, Inc. 64
Star Tribune 24
Stillwater Medical Group 64
THC Minneapolis 7
Veterans Affairs Medical Center–Michigan 48
Wenatchee Valley Clinic 52
Whitesell Medical Locums, Ltd. 52

STILLWATER
MEDICAL GROUP, P.A.

Be a part of a rapidly growing community in the historic city of Stillwater, MN.

An opportunity is available for a board certified physician in General Surgery in the scenic St. Croix River Valley.

- 42-physician, multi-specialty clinic, with two clinic locations in Stillwater, MN
- Comprehensive benefit package
- Excellent school system
- Ideal for families
- Located near the banks of the beautiful St. Croix River

If interested please call or send CV attention:
Liz Junker, H. R. & Benefit Specialist
921 S Greeley St.
Stillwater, MN 55082
(612) 439-1234 Ext. 327

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

UNIVERSITY OF MARYLAND AT BALTIMORE
SEP 23 1997
STACKS
REC'D.
NOT IN CIRC.



11968-40932 Exp: 12/1997
Univ. of Maryland
Health Sciences Lib.
111 S. Greene St
Baltimore, MD 21201-1583
3

Preserving patient trust

SEPTEMBER 1997

University of Maryland



THE
MEDICAL PROTECTIVE COMPANY ®

Professional Protection Exclusively since 1899

To reach your local office, call 800-344-1899.

GOLD CORPORATE AFFILIATE
MGMA
FOUNDED 1926
PROGRAM UNDERWRITER

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Dan Picasso.

DEPARTMENTS

2 ..... Editor's Notebook

24 .... Author Instructions

50 .... News Clips

54 .... CME in Minnesota

61 .... Classified Ads

64 .... Index to Advertisers

FACE TO FACE

6 **Tuned in to a New Era in Medicine** ..... Katie Colón
Incoming MMA president Kent S. Wilson, M.D., puts a new spin on the realities confronting physicians.

PERSPECTIVES

10 **A Crowded Room** ..... David S. Hatem, M.D.
A physician finds he must help his patients carry life's heavy bag.

COVER STORY

12 **The Doctor-Patient Bond: Covenant or Business Contract?** ..... Miriam K. Feldman
Can physicians preserve patient trust and *the bottom line?*

CLINICAL & HEALTH AFFAIRS

18 **The Use of Stereotactic Radiosurgery to Treat Neurological Tumors**
Walter E. Galicich, M.D., Walter A. Hall, M.D., and Kwan Cho, M.D.

25 **Bladder Stone Causing Renal Failure** ..... C.P. Sundaram, M.D., A.M. Houshiar, M.D., and P.K. Reddy, M.D.

EDITORIAL

27 **Searching for Cures: The Necessity of Animal Research** ..... Jasper R. Daube, M.D.
Our ability to reduce human suffering depends on humane animal research that is rigorously reviewed.

MEDICINE LAW & POLICY

30 **Consumer Rights in the Health Care Marketplace: Minnesota's 1997 Patient Protection Act** ..... Kimberly Halva, J.D., M.P.H.
New legislation seeks to give physicians more freedom and to empower patients to make informed decisions.

BOOK REVIEW

43 **Mount Sinai Remembered** ..... Reviewed by Burton S. Schwartz, M.D., F.A.C.P.
In "Mount Sinai Hospital of Minneapolis, Minnesota: A History," Fred Lyon, M.D., tells of a hospital founded in an era of anti-Semitism.

IN MEMORIAM

45 **A Tribute to Cassius Marcellus Clay Ellis III, M.D.** ..... John S. Najarian, M.D.

33 The Monitor

Highlights ..... *Medicare changes will mean fairer payment*
• *Summary of 1997 MMA Annual Meeting resolutions*

Professional Privilege

Are doctors special? Most of us would like to think so. Years of knowledge-packed training leading to a career of healing and caring sounds like the very definition of a noble profession. But unlike dukes and duchesses, physicians' claim to the title is not guaranteed. Allegations of conflict of interest and breach of patient trust leveled at the medical profession hit even harder than threats to economic security and clinical autonomy. This month, *Minnesota Medicine* looks at professionalism and asks whether doctors are losing it.



"Medicine's ethical codes have placed the doctor-patient relationship at the epicenter of physician behavior."

A profession is self-regulating, strives for excellence, possesses special knowledge that it continually enhances, serves others, and follows a code of conduct. By this definition, medicine qualifies. Medicine's ethical codes, like the Hippocratic Oath or the AMA's Medical Code of Ethics, have placed the doctor-patient relationship at the epicenter of physician behavior. The sine qua non of that relationship is trust. Society must trust doctors to use their informed judgment in diagnosing and treating patients. Patients must trust doctors to do what's best for them.

With the uncertainty of its inexact science, the conflicting demands of patients, family, and society, and the universal import of health, clinical medicine has always been a balancing act worthy of the Wallendas. But, as described in our cover story (page 12), somebody's shaking the wire; patient-physician trust is being threatened by dwindling dollars and pressured decision-making. Budget-crunched corporations and managed care organizations (MCOs) are putting the squeeze on providers through capitation, utilization controls, and micromanagement. Feeling the pinch, physicians are responding by seeing more patients, gaming the system-of-the-month, or looking for other income-generating opportunities.

These pressures would be mere economic curiosities were it not for their potential to influence physician decision-making. In this "new world," physicians make clinical decisions tainted by managed care rules, societal rules, and self-interest. MCOs make clinical decisions driven by pharmacy costs, tests ordered, and contracts signed. Legislatures make clinical decisions based on public heat and personal biases. No wonder patients worry about the "silent partner" in the exam room. No wonder patients are suing MCOs over clinical decisions made by doctors who were obeying company rules. No wonder Columbia/HCA stock incentives to physicians are the target of federal investigation.

Physician decisions about patients have never been pristine. The danger of self-interest existed in the old days of fee-for-service and unfettered physician action. In those days, autocratic doctors with no real regard for informed consent dictated care to submissive patients. Hardly an ideal patient-physician relationship.

We don't need to turn back the clock, but we do need physicians once again to be making clinical decisions based on science, tempered by economic reality, and divorced from conflict of interest. We need MCOs to realize that doctors don't want to bankrupt the system. We need the legislative silent gorillas to leave the exam room. And, most of all, we need patients to trust that their doctors have trained minds as clear as humanly possible of ulterior motives.

Perhaps only collective societal decisions driven by medically guided research about what we want and what we can pay for will sanitize medical decision-making. Meanwhile, physicians will have to listen to that little voice that tells them what's right. Alistair Cooke once said that "a professional is someone who can do his best work when he doesn't feel like it." Historically, doctors have been special because they do their best for their patients—always.

–Charles R. Meyer, M.D., Editor-in-Chief

Partners In Your Future



"When I began my practice, there was a malpractice crisis in the United States. MMIC was there and they were very helpful. They have always been very supportive."

Judith Shank, MD
Metropolitan Dermatology
Plymouth, MN

In today's changing medical environment, physicians need to view their professional liability insurer as an important partner in their future. And what better partner can a physician have than a physician-owned and controlled liability insurer such as Midwest Medical Insurance Company. A company that understands a physician's desire to practice the art of medicine.

As your partner, MMIC is here to assist you in your new working relationships and to develop products and programs which improve patient care and lower liability exposures.

MMIC is here for the long term. We bring to the partnership a financial strength of over $251 million in assets and a total equity of over $104 million. Our rating from A.M. Best is A (EXCELLENT).

For a competitive quotation and other information on services offered by MMIC, please call us at 1-800-328-5532.

MMIC

MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S. Minneapolis, MN 55435-1891

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editors
Lee J. Engfer
Susan Rodsjo

Assistant Editor
Juliet Ramotar

Graphic Designers
Lee J. Engfer
Mike May
Susan Rodsjo

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine.* The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/DIAL MMA (342-5662).

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine.* Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1996-97 Officers

President
Raymond G. Christensen, M.D.

President-Elect
Kent S. Wilson, M.D.

Chair, Board of Trustees
Timothy J. Crimmins, M.D.

Vice President
Paul R. Hamann, M.D.

Secretary
Judith F. Shank, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Anthony C. Jaspers, M.D.

Vice Speaker of the House
Blanton Bessinger, M.D.

Past President
Michael J. Murray, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Kendra Flanagan

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Robert G. Milligan, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth Crabb, M.D.
Theodore L. Fritsche, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/DIAL MMA (342-5662)

Fax: 612/378-3875

E-mail: mma@mnmed.org

Web site: www.mnmed.org

CORRECTION

An article in the July issue of *Minnesota Medicine* ("International Medicine: Outside the Comfort Zone") inaccurately stated that a relief worker from the American Refugee Committee was killed by a land mine in Zaire. A spokesperson for ARC notes that the organization takes every precaution to ensure the safety of volunteers and staff; however, it cannot protect completely against hidden dangers such as land mines. In 1995 an ARC truck hit a land mine. No one was killed, but one worker lost both legs in the accident.








THIS PUBLICATION AVAILABLE FROM UMI

This publication is available from UMI in one or more of the following formats:

- In Microform--from our collection of over 18,000 periodicals and 7,000 newspapers
- In Paper--by the article or full issues through UMI Article Clearinghouse
- Electronically, on CD-ROM, online, and/or magnetic tape--a broad range of ProQuest databases available, including abstract-and-index, ASCII full-text, and innovative full-image format

Call toll-free 800-521-0600, ext. 2888, for more information, or fill out the coupon below:

Name _____

Title _____

Company/Institution _____

Address _____

City/State/Zip _____

Phone ( ) _____

I'm interested in the following title(s): _____

_____

UMI
A Bell & Howell Company
Box 78
300 North Zeeb Road
Ann Arbor, MI 48106
800-521-0600 toll-free
313-761-1203 fax

UMI

The Right Care . . . The Right Setting . . . The Right Time



As an extended, critical care hospital focusing on the acutely ill, medically complex patient, THC · Minneapolis aggressively transitions patients to the most appropriate level of care, whether that be a skilled nursing home, subacute facility or home health care. Such was the case with Mr. Ayott, 47 years old, who suffered severe injuries to his chest and lungs in a disastrous car accident. After being stabilized at an acute care hospital, Mr. Ayott transferred to THC to undergo ventilator weaning, wound care, and physical and occupational therapy. With a successful weaning rate of 78% and a new inpatient pulmonary program, THC made it possible for Mr. Ayott to receive the right care in the right setting at the right time.

THC Minneapolis
A Subsidiary of Transitional Hospitals Corporation

612-588-2750

Medically Complex Program · Pulmonary/Ventilator Program
Wound Care Program · Low Tolerance Rehabilitation Services

TUNED IN TO A NEW ERA IN MEDICINE

INCOMING MMA PRESIDENT KENT S. WILSON, M.D., PUTS A NEW SPIN ON THE REALITIES CONFRONTING PHYSICIANS.

BY KATIE COLÓN

Given the choice between historical nonfiction and a good novel, Kent S. Wilson, M.D., will pick a true-life drama almost every time. "I think it's much more fascinating than fiction," says Wilson, who recently took time out from a hectic day seeing patients at Otolaryngology & Head and Neck Surgery in St. Paul to talk about his goals for the Minnesota Medical Association. "I have always loved to read history—to learn how we got where we are today, and then try to figure out where we are going to go from here."

Indeed, it is with a veteran's understanding of the MMA's past and a clear vision for its future that Wilson will assume leadership as the association's president later this month. An active MMA member for the better part of three decades, Wilson is well-acquainted with the MMA's evolution. "We have a great deal to be proud of in our accomplishments," he says. "The medical association has had a significant influence on society as a whole and has benefited individual physicians as well."

From 1989 to '96, Wilson says, the association devoted tremendous resources to responding to the health care reform crisis. Now it's time to move on. "My job as president is to say that health care reform is over as the exclusive focus," Wilson avows. "We need to turn our attention to more traditional issues that have new spins and involve new realities."



PHOTOGRAPH BY JOHN NOLTNER

Born and raised in Bemidji, Minnesota, 56-year-old Wilson traces his interest in the medical profession to the high regard people had for doctors in his hometown. "The physicians in Bemidji were exemplary," he explains. "They had high standards for medical care and community participation. Medicine was something I aspired to because it was a respected profession in which you could help individual patients and have an important role in the community."

Inquisitiveness also played a part in Wilson's career choice. "I've always been curious about why things work the way they do," he says. During his residency and fellowship at the University of Minnesota in the late 1960s and early'70s, Wilson was impressed by the strides medicine was making in open-heart surgery. He himself did bench research in cryosurgery and immunology, as well as public health research on facial injuries in football and hockey players.

"As physicians, I believe we have three charges: to deliver good patient care; to be community oriented; and to be professionally curious." His own research currently focuses on the acoustic spectrum of human snoring and its relationship to polysomnographic parameters—or, just how loud can a snore get?

After earning his medical degree from the University of Minnesota in 1966, Wilson logged two years with the U.S. Public Health Service in New Orleans, where he did his surgical residency. He returned to the University of Minnesota to complete his fellowship in otolaryngology. He now serves as clinical assistant professor at the university in the departments of otolaryngology and family practice and community health.

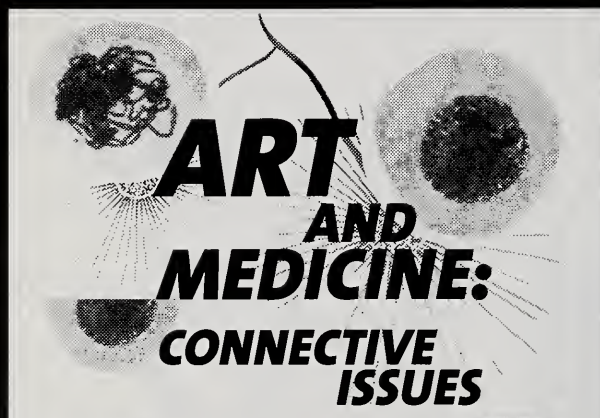
Wilson and his wife, Missy, live in the Highland Park area of St. Paul. Missy has a volunteer career with the Ramsey Medical Society Alliance and Children's–St. Paul. Their children, Christopher and Ann, are both married and each has one child.

AN INCREASINGLY DIVERSE MEMBERSHIP

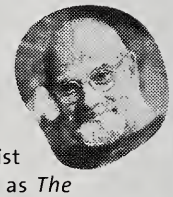
As incoming president, Wilson believes the MMA must reflect the changing face of the medical community. Within the last 10 years, more women and people of color have entered the field. At the same time, many formerly independent physicians now work for large health systems. The MMA's challenge, Wilson says, is to remain relevant to all these groups.

"One thing we have to consider is modifying physician representation in the MMA House of Delegates," he says. Historically, the MMA has been made up of individual physicians, each with equal access and equal representation, but many state and federal policies affect physician groups, not just individuals. *continued*

COPRESENTED BY
WALKER ART CENTER AND
THE MINNEAPOLIS MEDICAL RESEARCH FOUNDATION



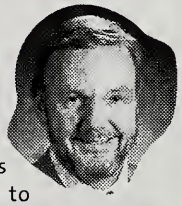
DR. OLIVER SACKS
CREATIVITY AND THE BRAIN
SUNDAY, OCTOBER 5, 3 PM, $12 ($6)*
THE GUTHRIE THEATER



Dr. Oliver Sacks, distinguished neurologist and noted author of such best-sellers as *The Man Who Mistook His Wife for a Hat, Awakenings,* and *Island of the Colorblind,* speaks about how brain function affects creativity.

*NOTE: Tickets for the Sacks lecture go on sale to Walker and MMRF members August 26. Tickets go on sale to the general public September 16 and are subject to availability.

DR. WALT WILSON
HISTORICAL VIGNETTES:
THE REPRESENTATION OF INFECTIOUS DISEASES IN ART
SUNDAY, NOVEMBER 2, 3 PM, $8 ($4)
WALKER AUDITORIUM



Dr. Wilson, professor of Medicine and Chief, Division of Infectious Diseases, Mayo Clinic, discusses the ways in which artists have represented diseases and other maladies and linked them to specific historical events. Wilson illustrates his presentation with a selection of representational paintings.

DR. BARBARA STAFFORD
THE AESTHETICS OF MEDICAL ETHICS
SUNDAY, NOVEMBER 23, 3 PM, $8 ($4)
WALKER AUDITORIUM



Dr. Stafford is an art historian, Distinguished Service Professor at the University of Chicago, a member of the Center for Clinical Medical Ethics, and author of *Good Looking: Essays on the Virtue of Images.* She discusses the impact new technologies have had on how we visualize the body.

WALKER ART CENTER
TICKETS: (612) 375-7622

It may make sense, suggests Wilson, to allow representation of clinic groups and employed physicians in the MMA House of Delegates. "There is precedent for this kind of thing—physicians are already represented geographically and by specialty groups."

FROM EMERGING DISEASES TO EMERGING TECHNOLOGY

In his new position, Wilson will shift his attention from history to history in the making. The subjects that engage physicians these days would satisfy any drama lover (and have, in fact, inspired a number of bestsellers). Among these are emerging diseases and resistant pathogens; environmental health concerns, like toxins possibly causing deformities in frogs; the impact of managed care; continuing debate about physician-assisted suicide; and scope of practice issues, such as naturopathic licensing.

Wilson also believes the time has come to focus seriously on alternative health. "There is a great deal of interest in alternative care methods among the public at large," he says, noting that patients spend some $13.7 billion annually on nontraditional therapies. "From the physician's perspective, we need to look at alternative treatments in the same way we view our standard medical activities, using scientific methods of investigation. If a certain treatment method proves effective and safe, the medical community should accept it. If it proves ineffective, we need to reject it."

Medicine is also immersed in a new age of "informatics"—the offspring of medicine and computer technology. As medical knowledge continues to explode, informatics puts computers at physicians' service to perform a wide range of tasks, from Internet searches to electronic recordkeeping and data transmission.

"The new information technology will affect all of us," says Wilson. "The MMA has a central role in educating the medical establishment as a whole regarding both the actualities and potentialities of informatics."

LEADERSHIP FOR A NEW ERA

Wilson emphasizes that the MMA is the only organization that supports all physicians in Minnesota. "We have a pre-eminent role in legislative efforts at the state and federal level in advocating for physicians' interests and concerns," he says. "We need to do a better job of identifying issues that span all specialties and of training leaders who are sensitive to these needs and have the skills to meet them.

"Put it all together," Wilson asserts, "and the challenge the association faces is to develop well-trained physician leaders for the 21st century—leaders who can confront a series of new realities with a new view of the world." MM

Katie Colón is a free-lance writer in Ramsey, Minnesota.

University of Maryland

Family Practice & Internal Medicine

The Austin Medical Center, part of Mayo Health System, has opportunities available for **Family Practice** and **Internal Medicine** BC/BE physicians.

This is a great opportunity to join a comprehensive, 41 physician, medical center which offers a full range of outpatient and inpatient services.

Our excellent compensation package includes two year salary guarantee plus incentive plan, bonuses, health, disability, life and professional liability insurance and pension.

Please send CV or contact Elizabeth A. Thissen at 1-800-747-4770

Austin Medical Center
Mayo Health System

1000 First Drive N.W.
Austin, MN 55912
1-800-747-4770 or
507-434-1474
Fax: 507-434-1477



G U L L L A K E

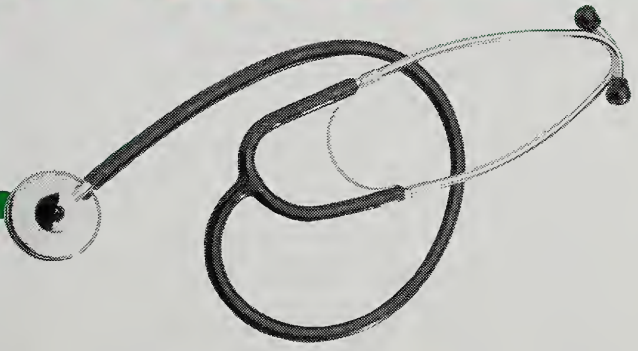
Quality construction, combined with unique architecture and professional decorating are but some of the highlights of this choice offering that includes three spacious bedrooms and three baths, private den, cathedral beamed ceilings, open balcony, three stone fireplaces, four season sun room with hot tub, cedar shake roof and a triple garage situated on 230' of beautifully landscaped frontage within 3½ miles of Madden's Classic Golf Course $698,000

KURILLA REAL ESTATE LTD.

Gary Kurilla
(218) 963-7333 or 800-987-0507
Kurilla Real Estate, Ltd.
P.O. Box 779
Nisswa, MN 56468
E-mail: lakehome@kurilla.com

www.startribune.com/workavenue

MAKE YOUR ROUNDS ON NEW GROUNDS.





Put your resume on WorkAvenue.com. It's a free, Star Tribune Internet Web site that automatically matches job openings with resumes from people in the health field and other industries. It's free, easy and confidential.* So go to the site. Because we make finding a new job painless.

If you don't have Internet access, send your resume to WorkAvenue.com, Star Tribune, P.O. Box 1617, Mpls., MN 55440-1617. It'll be electronically scanned and placed in the Workavenue.com database. For best results, call 612-673-9012 first.

*The confidentiality feature is only available when you enter your resume on-line.

www.startribune.com/workavenue

StarTribune
It's where you live.

970073R/7/97

A CROWDED Room

David S. Hatem, M.D.



I entered the exam room to find one of my scheduled patients waiting. I am often amazed at what patients bring with them when they visit their doctor. Not just what, but who. And not just who, but why.

She had brought her large bag of medical problems. In the bag was the breast cancer of 11 years, seemingly an old problem, but always present and early to come out of the bag. There was the recurrent lymphedema of one arm with intermittent cellulitis. There were the chronic headaches. There were the perplexing hot flashes. Cervical spondylosis, hypercholesterolemia, the positive PPD, the stroke of several years back (no residual deficit, but that didn't allow it to be discarded), and her periodic depressive episodes were all there, waiting to be taken out as necessary. Somewhere in the depths of the bag were the lining of her maxillary sinus as well as her uterus, which had been removed in the past. I stepped over the large bag.

She said she felt well today. Her throat had been sore and she had some neck pain at the site of the central line from a hospitalization several months ago. This was improving, however, and the examination of her throat and neck was unremarkable. Back into the bag went the central line. She was also concerned about a lump in her thigh that she had noticed several months ago and was now keeping her up at night. She undressed and put on a gown, allowing me to examine the leg that she was worried about. As she climbed up on the table, we conversed.

"How are things at home?" I inquired.

"The same," she replied.

Then, as she had done so many times before, she brought her daughter out of the bag and into the room.

"She's living with someone else after she just got rid of her old boyfriend."

Out came the new boyfriend.

"And she just had another baby."

Out he came.

"She only has the baby at home. The other four have been taken away. They're with her former husband. He takes good care of them."

He, who I hadn't even seen come into the room, got up and took four of the children with him.

Her daughter had schizophrenia and was in and out of treatment and in and out of relationships. Several of the relationships had led to marriages that were short-lived. Her mother often carried her daughter with her to our visits.

Recalling prior conversations with my patient about these issues, in my mind I drifted and brought her husband into the room. They had often disagreed about how to handle their daughter, and this led to some conflict that I imagined was as intense as she described it to me. Both felt strongly about how to deal with their daughter; they simply had different points of view. But I had brought him into the room without her knowledge this time, and so he simply sat there quietly.

I examined the lump on her thigh, finding only a lipoma whose appearance was exaggerated by some subcutaneous atrophy of the surrounding tissue. I informed her that there did not seem to be any need to worry. As she dressed, she escorted her sister into the room by asking, "Do you think this lump could be related to my cancer? My sister got breast cancer the year after I did. She had a lump like this and it turned out that the cancer had come back."

Her sister settled in.

I reassured my patient it was unlikely that the lump was cancer, but that we could follow it closely and do additional tests if the lump changed in size or appearance.

Her sister, who had died of the breast cancer, stayed close by her. Our visit was now over and as I filled out paperwork, she gathered together her belongings, her loved ones, her concerns. She escorted them out of the room and took them all home with her.

The room had seemed too small today for all she had brought with her, and all the reasons she needed to bring them along. The visit started with only neck pain and a lump on her thigh. There are no builders or clinic planners who could understand what had taken place today, or give me a room large enough. But it is not their job to understand this. It is our job to help carry the bag, to help reorder its contents, and sometimes to help the people for whom we care to discard some of the heavier contents of life's bag. We live and work in many crowded rooms, and I only hope that I can take the time to notice and greet everyone who is there. MM

David Hatem is a physician in Worcester, Massachusetts.

Reprinted with permission from JAMA 1997;277 (17):1350. *© 1997 American Medical Association.*

THE Doctor-patient bond:

Can physicians preserve patient trust *and* the bottom line?



The MC word. It strikes fear in patients who wonder whether they're getting the best medical treatment. It frustrates doctors who feel caught between a covenant to do no harm and a contract to contain costs.

Managed care. For many it has become synonymous with lost professional autonomy, gag rules, capitation, profit margins, and bottom lines. Although the situation is certainly less extreme in Minnesota, land of nonprofit health plans, nationally, managed care has launched a thousand horror stories. Consider, for example, the recent *Wall Street Journal* report about a boy left brain damaged and blind after a managed care gatekeeper refused to approve an MRI. It's just the flu, the gatekeeper said, but a belated MRI revealed an abscess in the boy's brain.

It's impossible to pick up a newspaper, magazine, or medical journal these days without coming across an article that speaks to our national anxiety over health care. Has the new health care system, created to cure the excesses

By Miriam K. Feldman

Covenant or business contract?

of the past three decades, gone too far? Has it seriously compromised the physician-patient relationship?

Nearly two years ago, in a cover story on managed care, *Time* magazine put it bluntly: "The most fundamental question raised by the new medicine is: Can you still trust your doctor?"

Not anymore, insists Dianne L. Shea, founder of Patients Aware Together (PAT), which tries to educate the public about managed care and its underlying financial incentives. Shea, of Minneapolis, trusted her doctor until four years ago, when her husband, Pat, died of a heart attack at age 40. For eight months before his death, Pat Shea had complained to his doctor of chest pains, shortness of breath, tingling in his extremities, and dizziness, and he reported an extensive family history of heart disease. But when the Sheas pleaded for a referral to a cardiologist, they were told not to worry—Pat was young.

"You're in that examining room speaking to your doctor, and you don't realize there is a silent partner in those rooms with you," Shea says. That silent partner—the clinic, the health plan, or the contract—drives medical decisions, she asserts. "Would it ever enter your mind that your doctor wasn't acting on your behalf? We trusted our doctor with our lives."

Do No Harm

Trust is essential to the healing process, says Ralph Crawshaw, M.D., a clinical professor of psychiatry and public health and environmental medicine at Oregon Health Sciences Center. "The sacredness of the medical profession rests on the doctor-patient relationship," he says. "The first principle is: 'Do no harm to your patients.' You are a powerful person relative to a less powerful, dependent person."

Crawshaw, who has been studying medical oaths for three decades, has found that more physicians are reciting an oath than ever before. (Most U.S. medical schools administer a version of the Hippocratic Oath or a more contemporary pledge.) Yet, ironically, the relationship physicians swear to uphold has never been more endangered. The medical profession must reaffirm the primacy of its obligation to the patient, Crawshaw says. "We know the tradition is being threatened. It will be replaced by [physicians] becoming agents of for-profit organizations."

Minnesota Nice

It's a different story in Minnesota, where health care organizations must be nonprofit, say the state's managed care leaders. Profits are returned to consumers, not shareholders, they argue. Minnesota isn't Massachusetts or California or any other state where large, for-profit health care organizations have gained a foothold in recent years, they say. It's different from the coasts, where physicians have been forced to move from fee-for-service to managed care in just one or two years. Minnesota physicians grew up with managed care. They even helped create it. Besides, Minnesota is nice.

"In Minnesota, physicians either sponsored or endorsed all the start-up managed care organizations," says John Kleinman, M.D., vice president of clinical services at Allina Health System. He cites Park Nicollet, MedCenters, Share Health Plan, and PHP/Medica as large organizations that physicians helped create.

Even *The Wall Street Journal* article about the boy who was denied an MRI singled out Minnesota's HealthPartners as an organization that lives up to managed care's claims: It integrates care and lowers costs and provides better treatment than an individual doctor in a traditional practice, without sacrificing physician autonomy. Similarly, a recent CBS "Eye on America" report on managed care praised Allina with its health plan, Medica, as a managed care organization that works.

"There's a difference between managed care that *The New York Times* writes about and managed care in Minnesota," says Tom Knabel, M.D., associate medical director of quality and utilization management with HealthPartners. "We don't have all the awful things you read about in *The New York Times*. We don't have gag clauses. We don't have incentives for treating people differently."

But is Minnesota really all that different? Raymond Christensen, M.D., Minnesota Medical Association president, believes the physician-patient relationship has been eroded by the new medicine. "But I don't think it's all gone," he says.

"I'm not saying managed care is bad. But it started the erosion of

trust," Christensen adds, noting that managed care has forced physicians to accept financial risk in order to contain costs. "On a population that's fine. But on an individual basis, patients realize their physicians' incomes are dependent on how they practice.

"Patients do not like the perception that physicians are rewarded for withholding care," says Christensen, who is a family physician at Gateway Family Health Clinic in Moose Lake. "Managed care, gatekeeper, HMO. Those are words that patients are not comfortable with."

That's exactly what Allina discovered when it asked its health plan enrollees what they thought about managed care. "They reacted negatively," Kleinman says. "But when asked about Medica, they said, 'That's my health plan. I like it.' " They didn't make the connection between managed care and their own health plan, which happens to be the state's largest managed care organization.



ILLUSTRATIONS BY DAN PICASSO

In fact, Minnesotans are generally satisfied with their health care, whatever the plan, according to a report by the Minnesota Health Data Institute (MHDI), a public-private partnership created by Minnesota statute. In 1995, MHDI interviewed more than 17,500 Minnesotans enrolled in 46 separate health plans, including managed care and fee-for-service plans, to develop standardized, comparative information regarding enrollee perceptions of their health plans and medical care. Over 92 percent were satisfied with their health plans, including 76 percent who were very or extremely satisfied, according to the survey. Those results were considered high by national standards.

Trouble in Paradise

Still, there are signs of trouble in paradise. Medica sent a letter to its physicians in June announcing that health care costs must return to budgeted levels by year's end or a portion of the physicians' fees will be withheld. The letter cited rising health care costs as the reason behind this move and implored physicians to pay attention to frequency and intensity of inpatient and outpatient hospital services, professional services, pharmacy and in-office lab use, and imaging. The letter referred, though not by name, to Blue Cross and Blue Shield of Minnesota, which recently reduced reimbursement to some of its specialty physicians by as much as 10 percent.

But how does such belt-tightening affect the physician-patient relationship? While most people agree that costs had to be brought under control, the question is, have we gone from doing too much to not doing enough? As Oregon's Crawshaw says, "Doctors are, of course, very conscious of health expenses. Always have been and always should be. But the goal is not to make the profit, but to care for the patient."

Robert Meiches, M.D., vice president of medical affairs for Fairview Health System, fears doctors are losing the ability to form relationships with patients. "I, personally, think we need the advantages of a free market helping us manage the costs, with an appropriate set of boundaries that help assure we're not going too far, to assure the health care of the community."

The trick will be in establishing those boundaries. "Increasingly, we are treating health care as a commodity," Meiches says. "If we believe that it should be a commodity traded exclusively on the free market, like other widgets or services, then the economic pressures that drive the market are going to push in the direction of eroding that relationship."

In July, *JAMA* published an editorial asserting that a free-market approach to containing spiraling medical costs has succeeded but at a price. "The market has shown little interest in preserving the sanctity of the physician-patient relationship," stated the editorial, which was signed by four medical ethicists, including Arthur Caplan, Ph.D., former head of the University of Minnesota's Center for Bioethics and currently director of the Center for Bioethics at the University of Pennsylvania Medical Center.

Ronald Cranford, M.D., chair of the MMA Committee on Ethics and Medical-Legal Affairs, agrees. "The bottom line in managed care is eroding

the patient-physician relationship. More than ever before."

The Rule of One vs. Community Care

The situation could improve, however, if physicians and patients face up to the choices they must make, says Cranford, a neurologist and clinical ethicist at Hennepin County Medical Center. He suggests that a healthy system would allocate resources by balancing individual needs with community needs.

As Kleinman puts it: "Society will have to decide whether the 'rule of one' prevails because there may not be enough resources to care for all. There is going to have to be some societal, ethical response to rationing resources. That's the direction we should move."

Others agree that some new approach—a new way of thinking—is needed. Michael Scandrett, executive director of the Minnesota Council of Health Plans, says the struggle will be to connect individual physician and patient decision-making to group decision-making and allocation of resources.

Collective Judgment

By its very nature, managed care moves decision-making away from the individual physician and into an organizational setting. At the group practice level, that means groups of physicians try to set guidelines about appropriate care, explains John Kralewski, Ph.D., professor and director of the Division of Health Services Research and Policy at the University of Minnesota's School of Public Health. When judgment moves a little away from the practicing physician, it probably improves care because of collective judgment, Kralewski says.

HealthPartners' Knabel agrees that collective judgment changes things for the better. "If you have 100 doctors in independent practice, no one knows how well they're taking care of folks with particular procedures. In a managed care environment, we collect data. It's more organized. We see how well people do things. We try to help them do it better. No one's ever looking when you're off on your own."

It's when decision-making moves farther up the organizational ladder, particularly in large managed care organizations, that some doctors become uncomfortable, Kralewski says. "How do you get doctors to practice cost-effective medicine but use resources when they need them? That gets tougher. That's when the doctors get upset over the whole thing. They think someone's telling them how to practice medicine. And it's true."

But oversight isn't necessarily bad, insists Scandrett. "You can either look at it as Big Brother, or as more accountability and assurances that good medicine is being practiced."

Christensen believes it's the latter. "I know there's a PRO out there. I'm glad it's there," he says. "Two of us started a practice in a rural community. We were out here alone for many years. The question we had was, 'Are we practicing in the mainstream? Are we doing what's appropriate? Are we up to date?' Now we know we are."

Time to Take Charge

For the physician-patient relationship to survive, physicians must take charge. While acknowledging that market forces have put pressure on the relationship, Meiches says if the system is broken, physicians will have to be the ones to fix it.



In July, Massachusetts doctors called for a moratorium on corporate takeovers of health services and demanded curbs on intrusions into their decision-making. "Mounting shadows darken our calling and threaten to transform healing from a covenant into a business contract," they wrote in a petition that will appear in the October *JAMA*.

As Cranford sees it, one solution will be for physicians to control the gatekeeping function. "Doctors in the U.S. are horrified by the term 'gatekeepers,' " he says. But he says the system can't work without gatekeepers. And, he adds, "The gatekeeper has to be a doctor."

Maureen Reed, M.D., HealthPartners' medical director for contracted

care division, says physicians must demand research that yields sound evidence about treatments and diagnostic procedures. "We need to demand that we obtain research results that tell us what is medically sound practice. And secondly, we need to recommend to our patients the best medical treatment based on that evidence and the needs of our patients."

It's important for physicians to give their best medical judgment, regardless of what the health plan allows. That might mean patients will pay out of pocket, but at least they won't suspect that some vital information is being withheld for an economic reason, Christensen says.

HealthPartners' Knabel agrees that physicians must lay everything out for the patient. "In the old days, if I thought patients needed something, I'd send them to the surgeon. Now I have to say, 'I think you need breast reduction mammoplasty, but I'm not sure your insurance covers it.' "

Patients also have a responsibility to understand their health plans and to speak up. This spring, the Minnesota Legislature passed the Patient Protection Act (see related article, page 30), which requires health plans to reveal financial incentives to patients on request. While the bill didn't go far enough for PAT's Dianne Shea, who lobbied for a tougher disclosure bill, it is "a step forward in allowing us to have knowledge," she says.

Through her work with PAT, Shea encourages patients to ask physicians about their financial arrangements. "They need to ask up-front, 'Doctor, are you making this decision because it's the best course of treatment, or because of my insurance carrier and your financial incentive?' "

Time will tell whether any of these measures is enough to repair a broken trust. As Christensen says: "The physicians of Minnesota have addressed this issue probably longer than others have, and have hopefully moved through it."

Meiches sees us on a pendulum. "We're swinging to a health care system that's governed by the free market. It's done very well for America. The question is, if we continue to treat health care as a commodity, are we losing things that we will regret?" MM

Miriam Feldman, a free-lance writer in Minneapolis, is a frequent contributor to Minnesota Medicine.

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 25 member medical staff has openings in the areas of:

Family Medicine **General Surgery**
Orthopedic Surgery **Psychiatry**
OB/GYN **Podiatry**

CHISAGO HEALTH SERVICES
A subsidiary of Fairview

Please contact:
Physician Recruitment and Retention Department
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454
1-800-842-6469

Announcing the opening of Bone, Muscle & Joint Inc.'s Midwest Regional Development Office

BMJI is a single specialty musculoskeletal Physician Practice Management (PPM) company.

BMJI assists with the business operations of your practice, restoring the pleasure of being a physician.

Bone, Muscle & Joint's Philosophy...

- Majority Physician Ownership
- Physician/Practice Autonomy
- Physician & BMJ Interests Fully Aligned
- Managed Regional Operating Teams
- Managed Care Network Development
- Focus On Worker's Comp



Bone, Muscle & Joint, Inc.

For more information call 1-800-414-BMJI (2654)
or in the Midwest 1-630-904-8232

Continuing Medical Education

Hennepin County Medical Center Activities



Through the Eyes of Others: Envisioning Culturally Competent Health Care
September 19-20
Earle Brown Heritage Center, Brooklyn Center
10.75 Credit Hours



Domestic Violence: On The Front Lines
October 15
(October is Domestic Violence Awareness Month)
Pillsbury Auditorium, Hennepin County Medical Center
Approx. 6.50 Credit Hours

Annual Ambulance Medical Directors Retreat
September 12-14
Radisson Arrowwood Conference Center, Alexandria
10.25 Credit Hours

Annual Forensic Science Seminar
October 2-3
Pillsbury Auditorium, Hennepin County Medical Center, Minneapolis
11.25 Credit Hours

Research Statistics Course
October 2-3
Hennepin County Medical Center, Minneapolis
12.25 Credit Hours

Annual Orthopaedic and Trauma Seminar
October 3-5
Minneapolis Convention Center, Minneapolis
19.0 Credit Hours

Clinical Research Methods Course
October 9-10
Hennepin County Medical Center, Minneapolis
Approx. 12.0 Credit Hours

Infection Control
Infection Control lectures, required by the MN Medical Practice Board for physicians, are offered on a continuing basis throughout the year. These lectures are held in the HCMC Pillsbury Auditorium over the noon hour. Please contact our office for further information.

Looking Ahead: Osteoporosis and YOUR Practice (Tent. November 21-22), ECG For Primary Care Physicians (December 4), and Annual Family Practice Update (December 5)

We have a full schedule of winter CME activities. Please contact our office for more information, or watch for future listing of events.

Hennepin County Medical Center
HCMC
Level 1 Trauma Center

For further information or registration materials please contact:
Hennepin County Medical Center • Continuing Medical Education
701 Park Avenue, Mail Code 869-A • Minneapolis, MN 55415-1829
Telephone (612) 347-2075, or Fax (612) 904-4210,
or TOLL FREE (888)263-4262 (CME@HCMC)

The Use of Stereotactic Radiosurgery to Treat Neurological Tumors

Walter E. Galicich, M.D., Walter A. Hall, M.D., and Kwan Cho, M.D.

ABSTRACT

Stereatactic radiosurgery is the precise delivery of a single dose of radiation to a well-defined intracranial volume. The radiation field is contoured to encompass the entire pathologic entity. Radiosurgery is used to treat a wide variety of neurological diseases as either primary or adjuvant therapy. It is a noninvasive and sometimes curative treatment for some brain tumors and inoperable arteriovenous malformations. Radiosurgery can also be used for inaccessible benign neoplasms or in medically unstable patients unable to withstand surgery. This article reviews the literature pertaining to stereatactic radiosurgery and includes our preliminary data from radiosurgery treatments at the University of Minnesota Hospital and Clinic (now Fairview-University Medical Center).

Stereotactic radiosurgery precisely delivers a high dose of radiation to a discrete intracranial volume. The adjacent normal brain parenchyma receives only a small, inconsequential amount of radiation. Conventional radiation therapy lacks the accuracy and specificity of radiosurgery.

Radiosurgery has been used since 1951 to treat more than 20,000 patients for a wide spectrum of illnesses[1] (see Table 1). Currently, this form of radiation therapy is used primarily to treat benign and malignant intracranial neoplasms and arteriovenous malformations (AVMs). Commonly treated tumors include meningiomas, acoustic schwannomas, pituitary adenomas, brain metastases, and some primary brain tumors.

With stereotactic radiosurgery, the radiation is delivered from several directions, eventually converging on the target area within the head. The point of focus is usually the area of maximum dosage, with a rapid decrease in the amount of radiation delivered to the surrounding brain. Two types of stereotactic radiosurgery devices have been used to treat the majority of patients considered appropriate for this therapy.

Linear accelerator (LINAC) radiosurgery uses a conventional radiation therapy linear accelerator system, with specific modifications (see Figure 1). Changing the collimator ensures the increased accuracy necessary for stereotactic radiosurgery. In LINAC radiosurgery, the radiation is delivered using multiple noncoplanar converging arcs. These arcs of radiation are generated by the rotation of the treatment table and the linear accelerator gantry around a target-centered axis.

The other system used is the Gamma Knife, which uses 201 radioactive cobalt sources arranged hemispherically in a large shielding vessel (see Figure 2). The patient is held in a precise position within the vessel, and the radiation is delivered through collimators (ports) of different sizes from multiple directions. Only the target volume, where the beams converge, receives the prescribed dose of radiation.

Advantages of the LINAC system include its lower cost and a treatment field of unlimited size and shape. The major disadvantage is the elaborate quality assurance measures required to calibrate the multiple moving parts. The Gamma Knife has no moving parts, which helps assure accuracy, simplifies treatment planning, and requires less medical physics expertise. Disadvantages of the Gamma Knife include its high cost, the necessity of replacing the cobalt sources every five to 10 years, and severe limitations in treatment field size and shape.

We reviewed the first 219 patients treated with LINAC stereotactic radiosurgery at the University of Minnesota Hospital and Clinic (now Fairview-University Medical Center). We discuss our results and summarize some of the literature pertaining to the treatment of AVMs, metastatic lesions, gliomas, acoustic schwannomas, and meningiomas.

Materials and Methods

Two hundred and nineteen patients were treated with a 6 MeV LINAC radiosurgery system from March 1991 to March 1995 (see Table 2). The entire procedure is performed on an outpatient basis in a single day and begins with placement of the Brown-Roberts-Wells stereotactic head frame* using local anesthesia. General anes-

*Radionics, Inc., Burlington, Massachusetts

Table 1

Clinical conditions treated with stereotactic radiosurgery

Acoustic schwannoma
Acromegaly
Anaplastic astrocytoma
Angiographically occult vascular malformation
Anxiety
Arterial aneurysm
Arteriovenous malformation
Carotid cavernous fistula
Cavernous angioma
Chondrosarcoma
Chordoma
Choroid plexus papilloma
Craniopharyngioma
Cushing's disease
Ependymoma
Epilepsy
Germinoma
Glioblastoma multiforme
Glomus jugulare tumor
Hemangioblastoma
Intractable pain
Low-grade astrocytoma
Lymphoma
Medulloblastoma
Meningioma
Metastatic brain tumor
Nasopharyngeal carcinoma
Nelson's syndrome
Nonsecreting pituitary adenoma
Obsessive-compulsive behavior
Ocular melanoma
Oligodendroglioma
Parkinson's disease
Pinealblastoma
Pinealcytoma
Prolactinoma
Trigeminal neuralgia
Trigeminal schwannoma
Venous angioma

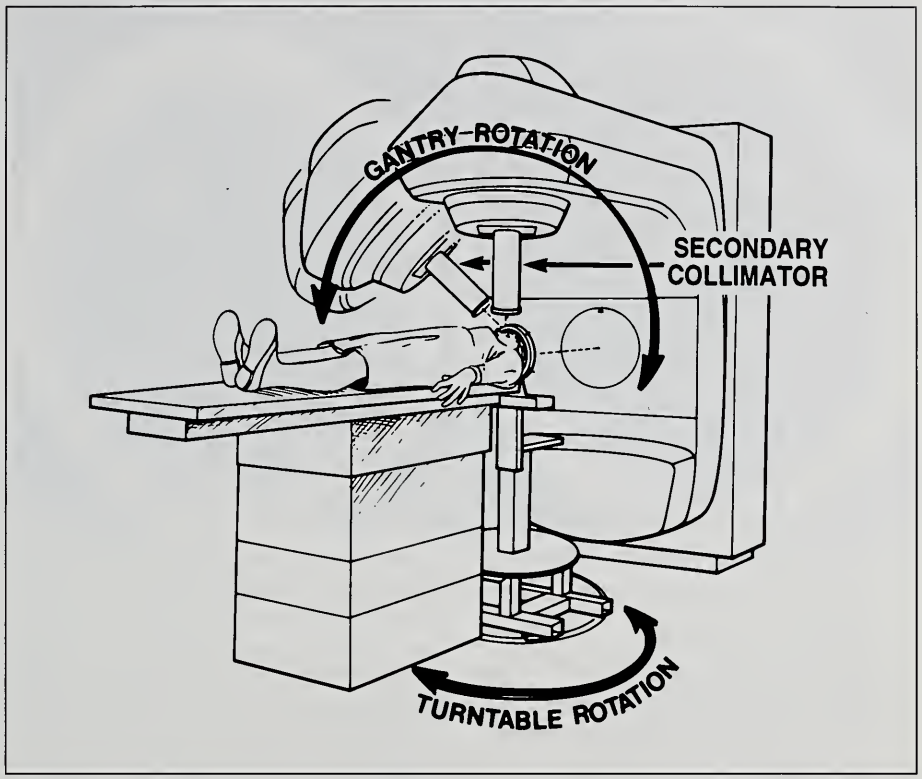


FIGURE 1—LINAC stereotactic radiosurgery. (Reprinted with permission from Alexander E III, Loeffler JS, Lunsford LD, eds. Stereotactic radiosurgery. New York: McGraw-Hill, 1993.)

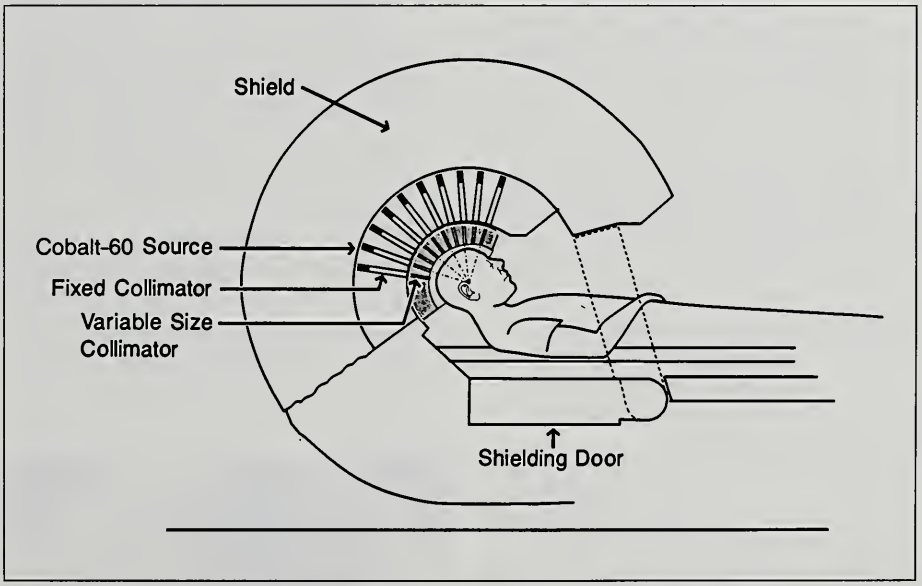


FIGURE 2—Gamma Knife radiosurgery. (Reprinted with permission from Alexander E III, Loeffler JS, Lunsford LD, eds. Stereotactic radiosurgery. New York: McGraw Hill,1993.)

thesia is necessary for pediatric patients. A CT, MRI, cerebral angiogram, or combination of these studies is performed and the images transferred to a computer workstation.

A neurosurgeon, medical physicist, and radiation oncologist plan the treatment, a process that takes several hours. The target area, which encompasses the pathology, is defined in relation to the stereotactic head frame. Several arcs through which the radiation can be delivered are generated. These arcs are designed to minimize radiation to particularly radiosensitive structures, such as the optic pathway, cranial nerves, and brain stem. The medical team determines an appropriate radiation dose after considering lesion histology, location, previous radiation treatment, and treatment volume.

The medical team performs a series of tests to verify the accuracy of the linear accelerator to within 0.2 mm±0.1 mm before each use. The patient's stereotactic head frame is attached to a floor mount† and the

†Philips SRS200, London, United Kingdom

Table 2

Histology of patients treated with stereotactic radiosurgery at the University of Minnesota from March 1991 to March 1995

Metastasis (one or more)	63
Arteriovenous malformation	45
Glioblastoma multiforme	34
Meningioma	25
Low-grade astrocytoma*	13
Anaplastic astrocytoma	12
Acoustic schwannoma	10
Miscellaneous	17
Total	219

*Radiosurgery was used as a boost in combination with conventional radiation therapy.

computed radiation treatment plan is delivered over several minutes. The stereotactic head frame is then removed and the patient discharged.

Results and Discussion

Arteriovenous malformations (AVMs)

AVMs are an abnormal cluster of blood vessels in which arteries connect directly to veins without the normal intervening capillary bed. AVMs tend to occur in younger people and present with hemorrhage or as an epileptic focus causing seizures.

Stereotactic radiosurgery is usually reserved for AVMs considered inoperable by an experienced vascular neurosurgeon. Radiosurgery can be used alone or in combination with endovascular obliteration by an interventional neuroradiologist.

Radiosurgery causes endothelial hyperplasia of the arterial vessels in the AVM, leading to progressive vascular occlusion.[2] Gradual thrombosis and obliteration is related to the size of the AVM and usually occurs over three years. If residual AVM is present after three years, retreatment with radiosurgery or surgery may be necessary.

One study reported that 65% of AVMs measuring less than 2.0 cm in diameter obliterated one year after radiosurgery.[3] Approximately 80% of AVMs were obliterated on cerebral angiography by two years.

As with untreated lesions, there is a risk of intracranial hemorrhage from the AVM until it is completely obliterated. One large study looking at the natural history of AVMs found that the annual risk of intracranial hemorrhage from an untreated AVM was approximately 4%.[4] It is uncertain whether radiosurgery protects against hemorrhage before complete obliteration occurs. One group of investigators showed a 4.8% risk of hemorrhage in the first six months following radiosurgery but no risk (0%) of hemorrhage after 12 months.[5]

Forty-five AVMs of various volumes (range=1.05 cm^3 to 48.3 cm^3; median=18.3 cm^3) have been treated with radiosurgery at the University of Minnesota Hospital and Clinic. These AVMs were considered inoperable because of their size or location or the patient's medical condition. After radiosurgery, these patients were evaluated with MRI every six months to monitor for obliteration. Once the MRI showed no residual AVM, one final angiogram was performed to confirm obliteration, usually at three years (see Figures 3a and 3b). Complications in this group of patients included two thalamic strokes, one case of radionecrosis treated with corticosteroids, and two hemorrhages. Of the 19 patients who have been followed for at least three years, 13 (68%) have achieved radiographically confirmed obliteration.

Metastatic lesions

Stereotactic radiosurgery has become an important treatment option for patients with brain metastases who have received conventional whole brain radiation therapy (see Figures 4a and 4b). Whether stereotactic radiosurgery by itself is sufficient treatment without conventional radiation therapy is a point of debate and under current clinical investigation.

Brain metastases have several characteristics that make radiosurgery an ideal treatment. These tumors are spherical, radiographically distinct from surrounding brain parenchyma, and displace, rather than infiltrate, surrounding tissue. Radiosurgery has been used to treat surgically inaccessible tumors and metastases that recur or persist after conventional radiation therapy. Metastases that are considered radioresistant to conventional fractionated radiation therapy will often respond to stereotactic radiosurgery.

Several large studies have demonstrated that stereotactic radiosurgery is very effective (>75%) for achieving local control of brain metastases, as evidenced by a decrease

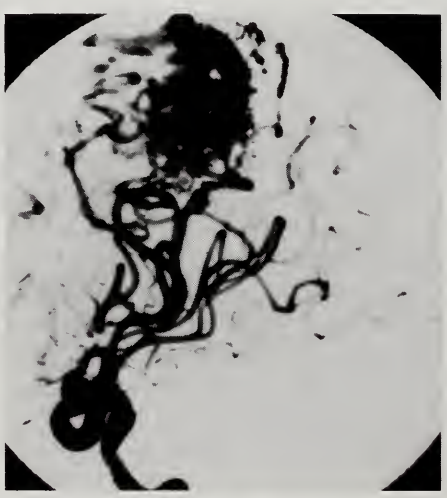


FIGURE 3a—Angiogram of large right posterior frontal AVM, lateral view.

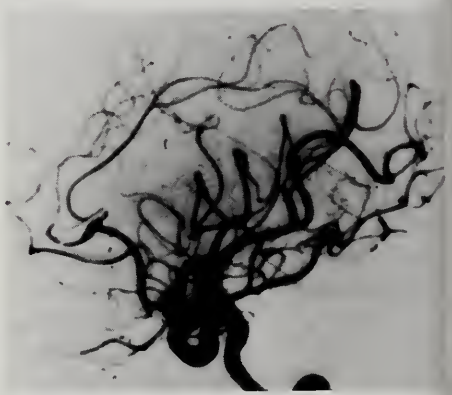


FIGURE 3b—Lateral angiogram of same patient three years after stereotactic radiosurgery. The AVM has been obliterated.

or stabilization of tumor size.[6,7] In one series following 282 metastatic lesions treated with LINAC radiosurgery, the local control rate was 94%. Follow-up in this study ranged from 1.5 to 72 months with a median of 9 months.[7] Other investigations have shown that radiosurgery improved patient quality of life and neurological status (Karnofsky scale) in addition to reducing glucocorticosteroid requirements for patients with brain metastases.[8]

As medical funding continues to decrease, several studies have evaluated the cost-effectiveness of stereotactic radiosurgery compared with conventional treatment modalities. One such study showed that treating solitary metastases with stereotactic radiosurgery was associated with reduced costs and shorter hospital stays.[9]

We have treated 25 patients with solitary brain metastasis over 3.5 years. Ten patients (40%) had lung carcinomas, five (20%) had malignant melanomas, three (12%) had unknown primary cancers, and seven (28%) had other primary cancers. Of 18 evaluable patients, local control was achieved in approximately 80%.[10]

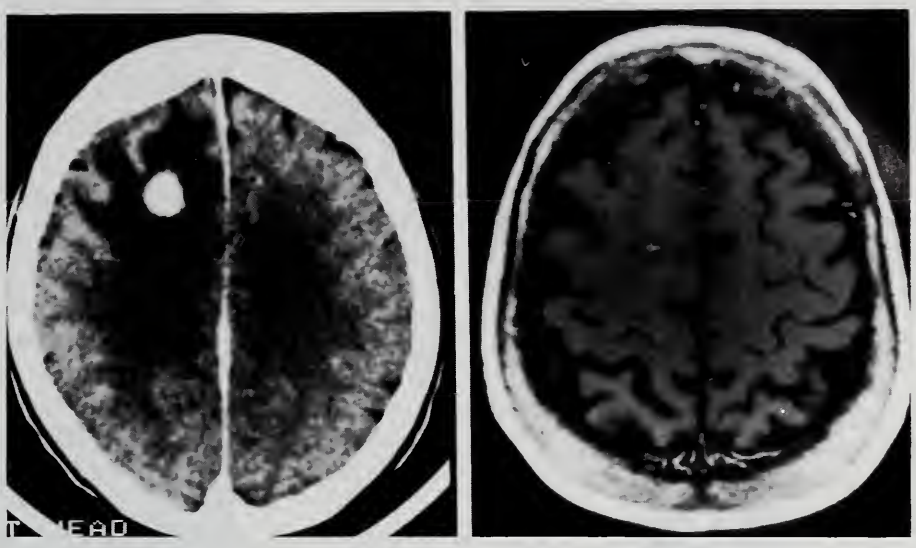


FIGURE 4a—Axial CT of uterine carcinoma metastasis. FIGURE 4b—Axial MRI of same patient six months after stereotactic radiosurgery, showing complete regression of lesion.

Astrocytomas

Astrocytomas are neoplasms that arise from the supportive glial cells of the brain. The prognosis for patients with astrocytomas is poor because of the infiltrative nature of these tumors and their ability to systemically suppress the immune system.[11] Based on the tumor's histology, an astrocytoma is classified as low-grade, malignant anaplastic, or glioblastoma multiforme. Despite surgery, conventional radiation therapy, and/or chemotherapy, there are few long-term survivors with malignant primary brain tumors. Stereotactic radiosurgery has been used primarily as adjuvant salvage therapy for malignant gliomas. The rationale for using this focused radiation technique in an infiltrative disease is to achieve local control, since most of these tumors recur locally after surgery.

We treated 25 malignant astrocytoma patients for whom conventional treatment had failed. Stereotactic radiosurgery for these high-grade tumors was found to be as effective as brachytherapy.[12] Brachytherapy, which involves surgical implantation of radioactive sources into a tumor, was associated with more complications and required a longer hospital stay than radiosurgery. In addition, the reoperative rate for patients treated with brachytherapy was significantly higher than for patients receiving radiosurgery.[13]

Acoustic tumors

Acoustic tumors are neoplasms that arise from the eighth cranial nerve in the posterior fossa. Currently, acoustic schwannomas are primarily treated with surgical resection. Most institutions reserve radiosurgery for patients with acoustic tumors who refuse surgery or who are poor surgical candidates. However, clinical trials in progress suggest that stereotactic radiosurgery may be a viable primary therapy for these tumors.

Studies at the University of Pittsburgh showed that 60% of acoustic tumors decreased in size and 40% stabilized at a follow-up of more than 20 months.[14] The four-year actuarial tumor control rate, defined as reduced tumor size or absence of growth, was 89.2±6% for 136 acoustic schwannomas.[15] Forty-five percent of patients had complete hearing function after two years.

In the 10 patients we treated for acoustic schwannomas, all tumors have remained stable or decreased in size and none of the patients has experienced facial weakness. However, longer follow-up and formal hearing evaluation is necessary for patients with these slow-growing tumors.

Meningiomas

Meningiomas develop from the arachnoid cells in the meninges of the brain and are usually well-encapsulated and slow-growing. These tumors are rarely invasive and usually present with neurological symptoms or seizures. Radiosurgery has been used to treat meningiomas in areas where surgery is technically difficult and complete removal unlikely. This technique is an alternative or adjunct to surgery in cases of recurrent or residual meningiomas. In one report, an actuarial control rate of 92% at four years was achieved for 94 meningiomas treated with radiosurgery.[16]

Of the 25 meningiomas we treated with radiosurgery, 18 patients have had radiographic and clinical follow-up. Growth stabilization or a decrease in tumor size occurred in all of these patients (100%) at a median follow-up of eight months. One patient in this group experienced an associated complication. This medically fragile patient developed hydrocephalus after radiosurgery for a posterior fossa meningioma. This patient was successfully treated with oral glucocorticoids and did not require further therapy. *continued*

Weigh The Facts!

Benefits to clinics, hospitals and practitioners include:
-Large pool of seasoned physicians.
-Integral part of medical referral network.
-Current in medical care policies, procedures and protocol.

To physicians of all specialties:
-Confidentiality prioritized.
-Financial incentives.
-Medical malpractice.
-Personalized service tailored to your needs.



Whitesell
Medical Locums, Ltd.

Eight First Avenue South
Buffalo, MN 55313
1(800) 876-7171
1(800) 295-6373
***Local* 682-5218 or 682-5906**
FAX (612) 682-4791

Emergency Physicians

BE/BC Emergency or Family Practice physicians are needed for the ED at St. Francis Hospital in Shakopee, a southwestern suburb. Full benefits provided.

Urgent Care Physicians

Opportunities available for Urgent care in Shakopee and Chaska, looking for Family Practice and Internal Medicine with pediatrics experience. Permanent part-time and moonlighting positions available, evening and weekend hours.

For Additional Information:

Debbie Modder
Allina Health System
Route 80775
5601 Smetana Drive
Minnetonka, MN 55343
612-992-3094 / 800-248-4921
Fax: 612-992-3669

Conclusion

Radiosurgery is a rapidly evolving primary or adjuvant therapy. Recent advancements in computer and imaging technology have made it a safe and effective treatment option for selected intracranial diseases. The noninvasive nature of radiosurgery makes it a reasonable alternative for patients who are unable to receive general anesthesia or for those who decline surgery.

For some patients with intracranial malignancies, stereotactic radiosurgery represents another treatment option when all other therapies have been exhausted. The technique can be used successfully as a primary therapy to obliterate small, difficult to reach arteriovenous malformations. Radiosurgery has also proven effective for the local control of brain metastases and for stabilizing the growth of acoustic tumors and meningiomas. MM

All authors are with the Fairview-University Medical Center in Minneapolis. Walter Galicich is a resident physician in the Department of Neurosurgery. Walter Hall is an associate professor in the departments of Neurosurgery and Radiation Oncology. Kwan Cho is an assistant professor in the Department of Radiation Oncology.

REFERENCES

1. Lunsford LD, Alexander E III, Loeffler J. General introduction: history of radiosurgery. In: Alexander E III, Loeffler JS, Lunsford LD, eds. Stereotactic radiosurgery. New York: McGraw-Hill, 1993:1-6.
2. Adams RD. The neuropathology of radiosurgery. Stereotact Funct Neurosurg 1991;57:82-6.
3. Leksell D. Special stereotactic techniques: stereotactic radiosurgery. In: Heilbrun PM, ed. Stereotactic neurosurgery. Baltimore: Williams & Wilkins, 1988:195-210.
4. Ondra SL, Troupp H, George ED, Schwab K. The natural history of symptomatic arteriovenous malformations of the brain: a 24-year follow-up assessment. J Neurosurg 1990;73:387-91.
5. Colombo F, Pozza F, Chierego G, et al. Linear accelerator radiosurgery of cerebral arteriovenous malformations: an update. Neurosurgery 1994;34:14-21.
6. Walsh JW. Stereotactic radiosurgery. In: Morantz RA, Walsh JW, eds. Brain tumors: a comprehensive text. New York: Marcel Dekker, 1994:693-717.
7. Loeffler JS, Alexander E III. Radiosurgery for the treatment of intracranial metastases. In: Alexander E III, Loeffler JS, Lunsford LD, eds. Stereotactic radiosurgery. New York: McGraw-Hill, 1993:197-206.
8. Mehta MP, Rozental JM, Levin AB, et al. Defining the role of radiosurgery in the management of brain metastases. Int J Radiat Oncol Biol Phys 1992;24:619-25.
9. Rutigliano MJ, Lunsford LD, Kondziolka D, et al. The cost effectiveness of stereotactic radiosurgery versus surgical resection in the treatment of solitary metastatic brain tumors. Neurosurgery 1995;37:445-55.
10. Cho KH, Hall WA, Gerbi BJ, Rohr M, Clark HB. Stereotactic radiosurgery for solitary brain metastases: a reasonable alternative. Journal of Radiosurgery, to be published.
11. Brooks WH, Netsky MG, Horowitz DA, Normansell DE. Depressed cell-mediated immunity in patients with primary intracranial tumors. J Exp Med 1972;136: 1631-1747.
12. Hall WA, Djalilian HR, Sperduto PW, et al. Stereotactic radiosurgery for recurrent malignant gliomas. J Clin Oncol 1995; 13:1642-8.
13. Sneed PK, Larson DA, Gutin PH. Brachytherapy and hyperthermia for malignant astrocytomas. Semin Oncol 1994; 21:186-97.
14. Loeffler JS, Alexander E III. The role of stereotactic radiosurgery in the management of intracranial tumors. Oncology 1990;4: 21-31.
15. Kondziolka D, Lunsford LD, Linskey ME, Flickinger JC. Skull base radiosurgery. In: Alexander E III, Loeffler JS, Lunsford LD, eds. Stereotactic radiosurgery. New York: McGraw-Hill, 1993:175-88.
16. Lunsford LD. Contemporary management of meningiomas: radiation therapy as an adjuvant and radiosurgery as an alternative to surgical removal? J Neurosurg 1994;80:187-90.

Credentialing "What If's"

A Powerful New Tool for Credentialing

- Provides a unique, hands on guide to the skills needed for credentialing
- Shows you how to decrease risk and assure the quality of potential providers
- Includes a step-by-step guide to credentialing processes and procedures

Please call (612)992-3095 for more information

Continuing Medical Education

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

SEPTEMBER, 1997

26 BRIDGING RESEARCH & PRACTICE: Focus on Effective Dissemination Strategies
Presented by: Allina Health System
Location: Radisson Hotel South & Plaza Hotel, Bloomington

OCTOBER, 1997

17 ADVANCED LIFE SUPPORT IN OBSTETRICS (ALSO)
Presented by: Allina Health System
Location: United Hospital, St. Paul

22 PRINCIPLES OF DIABETES
Presented by: Allina Health System
Location: United Hospital, St. Paul

NOVEMBER, 1997

21 - 22 NEW ULM FALL SEMINAR
Presented by: New Ulm Medical Center
Location: New Ulm Medical Center, New Ulm

For more information, contact Allina Clinical Education and Research - (612) 992-2424

™ A Trademark of Allina Health System

Visit the Allina CME calendar at http://www.allina.com

Park Nicollet Clinic
HealthSystem Minnesota

Pediatric Ophthalmology

Pediatric Ophthalmology: BC/BE team orientated Pediatric Ophthalmologist, fellowship trained, needed to join well established and well equipped Pediatric Ophthalmology practice. The Ophthalmology Department has ten physicians and is part of a 422 physician multispecialty group in the Twin Cities area. Comprehensive, generous benefit program. For additional information contact Patrick Moylan at (612) 993-5986 or send CV and letter of inquiry to Mr. Moylan, Professional Practice Resources, Park Nicollet Clinic HealthSystem Minnesota, 3800 Park Nicollet Blvd., St. Louis Park, MN 55416; or Fax (612) 993-2819.

FAMILY PHYSICIANS

The University of Minnesota Dept. of Family Practice and Community Health is seeking physician faculty for its state-of-the-art community residency program clinic affiliated with North Memorial Medical Center. Teaching, administrative, and full-range family practice clinical duties. Attractive benefits package. ABFP, MN license, teaching experience. Call Joseph M. Keenan, M.D., for full description and qualifications, (612) 624-2622, or view our Web page at:

http://www.med.umn.edu/fp/

The University of Minnesota is an Equal Opportunity Educator and Employer.

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.

3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Bladder Stone Causing Renal Failure

C.P. Sundaram, M.D., A.M. Houshiar, M.D., and P.K. Reddy, M.D.

ABSTRACT

We describe a 62-year-old man with a large bladder calculus causing bilateral ureteral obstruction. Diagnosis was delayed despite the patient's history of recurrent urinary infections. This case report illustrates the importance of radiological evaluation of patients presenting with recurrent urinary infections. To our knowledge, only three previous reports of bladder stone causing renal failure have been published.

Bladder stones are rare in the industrialized world. However, when overlooked, bladder stones can lead to complications caused by their growth. In this case report, we describe a patient with a large bladder stone causing renal failure due to bilateral ureteral obstruction.

Case Report

A 62-year-old man was admitted to a hospital with a history of anorexia and a 20-pound weight loss. The patient also complained of frequent urination and nocturnal incontinence. He had been treated with antibiotics over 18 months for recurrent urinary tract infections but had no history of flank pain, hematuria, or significant pyrexia. The patient had been investigated for anemia six months previously. Colonoscopy and upper GI endoscopy exams were normal. However, no urologic evaluation was done. His medical history included chronic renal impairment with a baseline creatinine of 2.0, hypertension, rectal prolapse, and hiatal hernia. Medications on admission were cimetidine, atenolol, Prilosec, and co-trimoxazole. The patient was emaciated, but apart from a rectal prolapse, his examination was unremarkable. Urinalysis revealed numerous red and white blood cells and bacteria. Serum creatinine was 9.2 g/dL. Other laboratory values included sodium, 128 mEq/L; potassium, 5.3 mEq/L; bicarbonate, 8 mEqL; white cell count, 15.2; and hemoglobin, 10.4 g/dL.

The patient was started on intravenous antibiotics and transferred to the medicine service at our hospital for management of renal failure. Urethral catheterization was difficult, and his urine output was minimal. Renal ultrasonography showed bilateral hydronephrosis. X-ray and CT scans of the abdomen and pelvis revealed a large bladder stone (see Figure 1).

We performed bilateral percutaneous nephrostomies to improve renal function before surgery. The patient underwent a vesicolithotomy. Operative findings included an inflamed bladder wall that was densely adherent to the stone. The bladder stone occupied the entire bladder, causing bilateral ureteral obstruction. Purulent fluid was present in the bladder. The prostate was small and nonobstructing. Postoperative nephrostogram revealed free flow of contrast into the bladder (see Figure 2). Nephrostomy catheters were removed on the 10th postoperative day. Serum creatinine returned to the patient's baseline of 2 g/dL. The stone, composed of magnesium ammonium phosphate, measured 7.5 cm by 5.3 cm by 4.2 cm and weighed 200 g. Culture of urine obtained during surgery grew *Enterococcus*, *Staphylococcus*, and *Streptococcus viridans*. Postoperative recovery was uneventful.

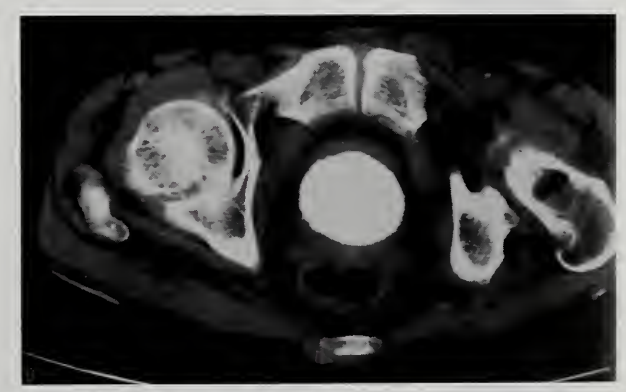


FIGURE 1—Large bladder stone seen on a CT scan of the pelvis.



FIGURE 2—Nephrostogram following vesicolithotomy confirming unobstructed flow of contrast into the bladder.

ful after treatment with intravenous antibiotics. The patient was asymptomatic during follow-up.

Discussion

Giant bladder stones occur in older men with bladder outlet obstruction. The largest stone, reported in 1921, weighed, 1,815 g.[1] Predisposing factors for developing a bladder stone are bladder outlet obstruction, neurogenic bladder, recurrent cystitis, vesical diverticula, and intravesical foreign bodies. These stones are usually symptomatic for a long period of time. In our patient, a urologic evaluation was not done despite his symptoms and recurrent urinary tract infections. This case report illustrates the pitfalls of treating urinary tract infections or presuming prostatism without conducting a urologic evaluation. Bladder stone causing bilateral ureteric obstruction has been reported previously on three occasions, to our knowledge.[2-4] Renal failure can be managed by removing the stone, thereby relieving the bilateral ureteral obstruction. If urosepsis is present, preliminary bilateral percutaneous nephrostomies are necessary.

Bladder stones are found primarily in the bladder or are passed into the bladder from the upper tracts. The procedure for managing giant bladder stones is usually open cystolithotomy. Smaller stones that are still too large for cystoscopic fragmentation have been treated with extracorporeal shock wave lithotripsy followed by cystoscopic removal of fragments[5] and percutaneous bladder surgery.[6] Bladder stones have been associated with carcinoma of the bladder. In a study of 602 patients with bladder stones, 3.26% of the patients also had a bladder tumor.[7] The incidence of malignancy with larger stones is likely to be higher, in view of the greater extent and longer duration of chronic inflammation; these patients should be closely followed. One patient died of carcinoma of the bladder four years after surgery for a huge vesical calculus.[2]

Conclusion

Large bladder stones can result in serious complications, including renal failure. Early investigation of recurrent urinary infections and persistent voiding symptoms can help ensure early diagnosis of bladder stones. MM

C.P. Sundaram is a fellow in endourology at Beth Israel Deaconess Medical Center, Harvard Medical School, in Boston, Massachusetts. He completed his residency in urology at the University of Minnesota in June 1997. A.M. Houshiar is chief resident in urology at the University of Minnesota. P.K. Reddy is chief of the Urology Section at the VA Medical Center in Minneapolis.

REFERENCES

1. Randall A. Giant vesical calculus. J Urol 1921;5:119-25.
2. Nygaard E, Terjesen T. Giant vesical calculus and anuria. Scand J Urol Nephrol 1976;10:88-90.
3. Becher RM, Tolia BM, Newman HR. Giant vesical calculus. JAMA 1978;239:2272-3.
4. Bapat RD, Kamdar MS, Bhaktiani K, Jathar H. Obstructive uropathy due to a vesical calculus around a foreign body. J Postgrad Med 1981;27:51-2.
5. Husain I , El-Faqih SR, Shamsuddin AB, Atassi R. Primary extracorporeal shockwave lithotripsy in management of large bladder calculi. J Endourol 1994;8:183-6.
6. Badlani GH, Douenias R, Smith AD. Percutaneous bladder procedures. Urol Clin North Am 1990;17:67-73.
7. Crenshaw JL. Vesical calculus. JAMA 1921;77:1071.

Red Lake, Minnesota

MAKE A DIFFERENCE!

Medical Director and full-time staff opportunities are available at Red Lake Hospital, operated by the Indian Health Service. Approximately 40-50 patients are seen per day, only 10-15% emergent care and 85-90% urgent care. 24 hour shifts are available.

Red Lake, Minnesota is within close proximity to Grand Rapids and a 35-minute commute to Bemidji.

Spectrum offers:
•competitive remuneration
•occurrence based malpractice insurance
Medical Directors also receive:
•comprehensive benefits including 401k
•stipend for administrative duties

Please contact Diana McClure at 800-325-2716 or FAX your CV to 314-919-8920 for immediate consideration.

Searching for Cures

The Necessity of Animal Research

Our ability to reduce human suffering depends on humane animal research that is rigorously reviewed.

Jasper R. Daube, M.D.

Physicians choose challenging careers in medicine for many reasons: to seek new knowledge, to apply their unique skills, and, most important, to help those who are hurting. We meet those challenges every day, often successfully, but always with a commitment to do our best. Our success results from our innate abilities, training, support staff, and the tools—medicine and equipment—we have to help us. These tools are increasingly at risk.

The new medications we have available for patients, as well as our many new diagnostic tools and surgical procedures, have been developed with the help of animal research. Despite the unquestionable importance of animal studies, animal rightists continue to try to stop these research efforts. Often they focus on seemingly small issues, but ultimately, their goal is to eliminate or severely curtail animal research.

As a neurologist, I am dedicated to reducing human suffering from neurologic diseases and minimizing the enormous economic cost of brain diseases. My work for the Decade of the Brain, as Congress so designated the 1990s, has made me aware that our understanding of brain diseases is at risk because of threats to animal research.

At the local level, school boards are being encouraged to prohibit the use of animals in classrooms. At the state level, laws are being proposed to restrict the use of animals in medical research. And at the national level, regulations have been proposed requiring that animal cages be enlarged by a few inches and adding other stipulations that markedly increase the cost of animal research with no benefit to animal well-being.

Advances from Animal Research

Numerous examples demonstrate the importance of animal research in medicine. New neurologic medications and diagnostic tools have all been developed with the aid of animal studies. Our ability to image the brain with MRI rather than the old method of pneumoencephalogram depended on testing the effects of magnetic resonance imaging on pig brains.

Animal studies are a valuable substitute for initial studies on humans. Testing of sumatriptan for migraines was initially done on rodents. Understanding the role of amyloid deposits in Alzheimer's disease is based on brain research in aging monkeys. Producing animal models of Parkinson's disease using the toxin MPTP has allowed us to test many therapies. New treatments for epilepsies were all tested initially on rodents. Research with mice and rats has shown the relationship between brain and behavior, which helps us understand learning disorders and mental retardation. Animal studies have helped researchers identify the genetic defects in Huntington's disease, in some forms of amyotrophic lateral sclerosis, and in many other degenerative diseases. Proteins that facilitate regrowth of axons in the central nervous system may offer therapies to improve recovery after brain injury. Animal research can aid us in identifying these proteins. Even the emerging therapies for AIDS and viral infections like herpes are all based on animal studies.

Animal research has led to significant developments in nearly every field of medicine: the vaccine for poliomyelitis, cardiac pacemakers, organ transplants, cardiac catheterization, open-heart surgery, cancer chemotherapy, radiation therapy, chemotherapy for childhood leukemia, gall stone surgery, alternative sources for factor VIII in hemophilia, and safe transfusions. Nobel prize-winning work in medicine over the last 90 years has relied on animal studies.

Virtually any patient we test or treat is better off because of animal studies that helped researchers develop new therapies. Yet the public too often takes our medical capabilities for granted. It sees the products of the research studies but does not hear about the thousands of small research steps that preceded those capabilities. It is our responsibility to inform patients about the importance of animal research.

Propaganda vs. Education

To do so, we must first recognize the animal rights campaign for what it is and take positive steps to combat it. We need to understand that for some animal

rightists, the goal is to end all human use of animals, including for food, clothing, sports, and even zoos. Ingrid Newkirk, codirector of People for the Ethical Treatment of Animals, a major animal rights organization, said, "A rat is a pig is a dog is a boy." This way of thinking has brought some animal rightists to commit violent acts against animal research facilities and individual researchers. A "60 Minutes" television report in 1993 described the kind of questionable tactics that such groups use. The report clearly showed how innuendo and outright misinformation resulted in the termination of an important research program on head injury at Louisiana State University.

Of greatest concern, though, is the heavily financed propaganda campaign to misinform the public about animal research, especially in grade schools and high schools. Many myths are repeated so often they appear to be true. But the facts are clear:

- Medicine uses animal research when it is the best alternative for finding an answer.
- Federal law mandates that animals be treated humanely, and it calls for rigorous oversight of review groups that must approve every research project using animals.
- More than 90 percent of research animals are rats, mice, and other rodents. Cats, dogs, and monkeys make up only a small proportion of the total, and they are used only when needed to provide answers to specific research questions.
- Most animals used for research are bred for that purpose, and their care is highly regulated.
- Many therapies used for the treatment of ill or injured animals are based on studies of other animals.

Physicians need to respond with their own campaigns to educate patients about the absolute necessity for continuing animal studies. The American Academy of Neurology has produced a brochure distributed in neurologists' offices that describes some specific benefits of

Use and Care of Animals in Research and Teaching

MMA Policy Statement

The Minnesota Medical Association supports the use of animals in the pursuit of biomedical research and in the teaching of health professionals. Millions of patients owe their health and lives to remarkable medical advances discovered during research that involves the use of animals. Indeed, there can be no doubt that animals play a critically important role in the vital research that saves human lives and reduces the burden of human disease and illness.

The Minnesota Medical Association is strongly committed to the conduct of research using animals according to high ethical standards that effectuate legal protections for the use of animals and ensure the humane treatment of animals used in research and teaching. In developing standards and guidelines for the conduct of research studies using animals, the Minnesota Medical Association urges physicians and other biomedical researchers to consider the following guiding principles.

Guiding Principles

RESPECT FOR ANIMAL WELFARE: Animals used in research should be treated humanely at all times. All involved in the research activity should be aware of the importance of assuring that humane treatment, clean and comfortable facilities, proper care and feeding, veterinary care, and the use of anesthesia or analgesics for painful procedures or postop care is available for animals used in research and teaching. Standards in this regard should conform to the Animal Welfare Act and any other relevant federal or state laws and regulations regarding animal welfare.

PEER REVIEWED, SCIENTIFICALLY sound research: Institutions conducting research involving animals should ensure that it is conducted with all necessary approvals from committees or peer review bodies (e.g., Animal Care Committee) charged with reviewing research projects for scientific soundness and compliance with applicable laws, regulation, policies, and procedures.

Through appropriate review committees, institutions conducting research involving animals should also give consideration to whether alternatives to animals or animal species may be appropriate. Projects involving animals should also be limited to the number absolutely necessary to conduct the research accurately.

RESPECT FOR AND KNOWLEDGE of the regulations enacted to protect animal research subjects: All research using animals should conform to guidelines and regulations established by state and federal governing bodies, including the United States Department of Agriculture, National Institutes of Health, and the United States Public Health Service.

The Minnesota Medical Association's animal research policy statement was developed by the MMA Committee on Ethics and Medical-Legal Affairs and adopted by the Board of Trustees in May 1997.

animal research in the field. The Massachusetts Medical Society developed a superb program to help physicians take the message into their communities. The American Medical Association continues to work to help physicians educate both their patients and their communities.

In addition, three important national lay groups support animal research. Incurably Ill for Animal Research (IIFAR), the National Association for Biomedical Research (NABR), and the Foundation for Biomedical Research (FBR) all produce materials for the public and monitor animal rights groups' activities. NABR is the only organization dedicated solely to advocating for animal research. Its monthly newsletter highlights important new knowledge generated by animal studies and reports on the ongoing activities of animal rights organizations.

Physicians in Minnesota can help by supporting the Minnesota Medical Association in its efforts to make the public aware of the importance of animal research and, even more important, by taking that message directly to patients with brochures, posters, and other media.

Conclusion

Extremists draw a line between humankind and the rest of the animal world and pit one against the other. They make it appear that for one side to win, the other must lose. They promote the rights of animals by reducing human rights. This is a false, lopsided view. While we must be concerned about animal suffering, we must also be concerned about lessening human suffering. The use of animals in medical science does not diminish the number of animals. Instead, it points to humankind's dependence on and debt to animals. MM

For more information, contact IIFAR at PO Box 27454, Lansing, MI 48909, 517/887-1141, and NABR/FBR at 818 Connecticut Avenue, Suite 303, Washington, D.C., 20006.

Jasper Daube is a neurologist at the Mayo Clinic and Mayo Foundation in Rochester, Minnesota.

Additional Reading

The following sources provide more detailed background on animal research in medicine.

- D.R. Schmahmann and L.J. Polacheck provide a strong argument in favor of animal research in "Case Against Rights for Animals," Environmental Affairs 1995;22:747-81.
- The August 1993 "Report to Congress on the Extent and Effects of Domestic and International Terrorism on Animal Enterprises," published by the U.S. Department of Justice, describes the activities of animal rightists.
- Katie McCabe's "Beyond Cruelty," published in the February 1990 *Washingtonian,* exposes the tactics of animal rightists.
- The 1989 American Medical Association White Paper, "Use of Animals in Biomedical Research: The Challenge and Response," is available from the AMA, 312/464-5000.

Wilderness Charm and Cosmopolitan Amenities

St. Mary's/Duluth Clinic Health System, a 300-physician multispecialty group, with 3 hospitals and 22 neighborhood & regional centers serving a referral population of 460,000, seeks physicians in the following areas:

EP Cardiology	Orthopedic Surgery
Dermatology	Ophthalmology-Retina
Emergency Medicine	Pathology
Family Practice	Pediatrics
Internal Medicine	Psychiatry – Adult
Nephrology	Psychiatry – Child
Neurosurgery	Rheumatology

We offer a complete compensation package, including excellent fringe benefits and generous vacation/CME time. Only here can you listen to a duet of loons and a symphony orchestra in the same evening.

Contact Mike Griffin Marci Jackson or Jocelyn Heid, SMDC, 400 E. 3rd St., #500, Duluth, MN 55805 or call 1-800-342-1388 or fax 218-722-9952 or e-mail to: sr@smdc.org

SMDC

St. Mary's/Duluth Clinic Health System eoe



G U L L L A K E

A magnificent view is offered through a forest of majestic virgin pine from this rustic and very private five bedroom, three bath lake home that includes cathedral beam ceilings, two fireplaces, huge decks and a triple garage all situated on 1.5 acres within two miles of Madden's Classic Golf Course $369,900

KURILLA REAL ESTATE LTD.

Gary Kurilla
(218) 963-7333 or 800-987-0507
Kurilla Real Estate, Ltd.
P.O. Box 779
Nisswa, MN 56468
E-mail: lakehome@kurilla.com

Consumer Rights in the Health Care Marketplace

Minnesota's 1997 Patient Protection Act

New legislation seeks to give physicians more freedom and to empower patients to make informed decisions.

Kimberly Halva, J.D., M.P.H.

During the 1996-97 legislative session, a coalition of health care organizations, consumer advocates, and the Minnesota attorney general's office asked the Legislature to address growing consumer concerns about the quality of medical care provided by the state's managed care organizations. The Legislature responded by enacting the Minnesota Patient Protection Act.* The act addresses, among other things, exclusive arrangements between health plans and providers, gag clauses, and access to emergency and specialty care.

Prohibition on Exclusive Arrangements

The Patient Protection Act attempts to give consumers more freedom to choose providers and providers more freedom to serve patients with different types of health coverage. To do this, the act prohibits exclusive arrangements between health plans and providers, unless a provider is an employee of the health plan. Exclusive arrangements include agreements that:

- restrict a provider from supplying health services or procedures to another provider, group of providers, or health plan;
- prohibit providers from contracting with other health plans for the provision of health care; and
- withhold from competitors health care services that are essential for competition between health care providers.[1]

Anyone who knows of an exclusive arrangement that violates one of these provisions may file a complaint with the Minnesota attorney general's office. The commissioners of health and commerce may also review contracts between health plans and providers to determine compliance with the act.[2] Any health plan or provider not in compliance may be assessed a fine of up to $2,500 per day for each day the contract is in effect.[2] Further, a health licensing board, such as the Board of Medical Practice, may take disciplinary action against a provider who enters into an exclusive arrangement prohibited under the act.[3]

Prohibition on 'Gag Clauses'

In addition to forbidding exclusive arrangements, the Patient Protection Act prohibits "gag clauses" in health plan-provider contracts. Specifically, Minnesota law defines as a gag clause any agreement that prohibits a health care provider from doing the following:

- communicating with an enrollee about the enrollee's health status, health care, or treatment options;
- making a recommendation regarding the suitability or desirability of a health plan;
- testifying, supporting, or opposing legislation;
- disclosing accurate information about whether services or treatments will be paid for by an enrollee's health insurance; or
- informing an enrollee about how the provider is reimbursed by the enrollee's health plan.[4]

These types of agreements can prevent physicians from advocating for their patients and giving them the information necessary to obtain full informed consent for care.

To ensure that health plans do not wrongfully impose gag clauses on providers, the Patient Protection Act also prohibits health plans from punishing providers who refuse to be bound by the terms of an illegal gag clause. A health plan may not punish a provider who refuses to enter into a prohibited agreement; who discloses accurate information about whether a treatment is covered by an enrollee's insurance; or who expresses disagreement with a health plan's decision to deny or limit services to an enrollee. Further, a health plan may not punish a provider who helps an enrollee seek reconsideration of a health plan's decision to limit coverage, so long as the provider makes it clear that he or she is not speaking as a representative of the health plan.[5]

Although a health plan may not punish a provider for refusing to be

*The Minnesota Reviser of Statutes intends to codify Chapter 237 of the Minnesota Session Laws at Minnesota Statutes § 62J.695 to § 62J.76. These sections will be collectively known as Minnesota's Patient Protection Act.

bound by a gag clause, it may punish a provider whose actions are illegal, constitute medical malpractice, or are contrary to accepted medical practice. Health plans may also require providers not to disclose the specifics of how much they are paid, provider fee schedules, and other proprietary information about the health plan.[6]

Access to Emergency Services and Specialty Care

The Patient Protection Act strives to guarantee uniform access to emergency health care services and specialty care. The act requires that all health plans provide emergency medical services to their enrollees 24 hours a day, seven days a week.[7] Health plans must inform enrollees about how to obtain emergency medical care and whether preauthorization is required. Interestingly, Minnesota statute 62M.07, enacted in 1992, states that no health plan may require prior authorization for emergency treatment. Because this statute provides more protection to health plan enrollees, its emergency services provisions will likely preempt similar provisions in the Patient Protection Act.†

The act also requires health plans to cover emergency services performed by participating and nonparticipating providers, either within or outside the health plan's service area. If a health plan does choose to deny an enrollee's claim for emergency medical services, it must consider the following factors:

- a reasonable layperson's belief that the circumstances required immediate medical care;
- the time of day and day of the week the care was provided;
- the enrollee's symptoms, including severe pain;
- the enrollee's efforts to follow the health plan's established procedures for obtaining emergency medical care; and
- any circumstances that precluded the enrollee from using the health plan's established procedures for obtaining emergency care.[7]

The Patient Protection Act also addresses enrollee access to specialty care. Under the act, health plans must allow enrollees to apply for, and if appropriate, receive, standing referrals to specialists.[8] The plans must specify the criteria necessary to obtain a standing referral.[8] Enrollees with standing referrals may see specialists without consulting their primary care physician. Unless the enrollee requests that a specialist become his or her primary care provider, however, the primary care provider remains responsible for coordinating the enrollee's care.[9]

Continuity of Care Assurance

Under the new act, health plans that require enrollees to access health care services through a primary care provider must have a written plan for ensuring continuity of care in case the contract between the health plan and an enrollee's primary care provider is terminated.[10] The written plan must explain how the health plan will inform the enrollee if the contract is terminated and how the enrollee can transfer to a new provider. It must also explain how the health plan will provide continuity of care for enrollees with special health needs.[10]

Health Plan Disclosure Requirements

To make sure consumers have adequate information for choosing a health plan, the Patient Protection Act requires health plans to disclose certain information about how they compensate their providers and how much they pay their executives. Specifically, health plans must give new enrollees a written description of the reimbursement methods they use to pay providers.[11] This information must be written in clear, understand-



†Section 8 of the Patient Protection Act provides that nothing in the act preempts or replaces requirements that are more protective of patients. 1997 Minn. Laws 237, § 8.

able language so enrollees can compare the compensation methods of different plans. Enrollees may also request, and health plans must supply, more detailed information regarding a plan's reimbursement methods, including a description of any financial incentives the health plan provides to the physician.[11]

All health plans must also file a list of their five highest-paid executives whose total compensation exceeds $50,000.[12] This information should be filed with the Consumer Advisory Board established by the Patient Protection Act. Upon filing, the information becomes public.[12]

Name Tags

The Patient Protection Act requires that every licensed, credentialed, or registered health care provider wear a name tag that identifies the provider and his or her occupation.[13] A provider who does not wear a name tag will not be subject to legal action, however.

Conclusion

The Patient Protection Act empowers health plan enrollees and providers to be fully informed about the benefits and restrictions associated with health plans in Minnesota. The goal is to give enrollees adequate information to make intelligent, informed choices about their health care, allow them access to emergency and specialty care, and assure that they will receive continuity of care in certain circumstances. For providers, the Patient Protection Act allows more freedom to serve patients. MM

Kimberly Halva is the associate legal counsel at the Minnesota Medical Association.

REFERENCES

1. 1997 Minn. Laws 237, § 5.
2. 1997 Minn. Laws 237, § 6, subd. 1.
3. 1997 Minn. Laws 237, § 6, subd. 2.
4. 1997 Minn. Laws 237, § 3, subd. 1.
5. 1997 Minn. Laws 237, § 3, subd. 3.
6. 1997 Minn. Laws 237, § 3, subd. 4.
7. 1997 Minn. Laws 237, § 11.
8. 1997 Minn. Laws 237, § 13, subd. 1.
9. 1997 Minn. Laws 237, § 13, subd. 2.
10. 1997 Minn. Laws 237, § 12, subd. 1.
11. 1997 Minn. Laws 237, § 4, subd. 1.
12. 1997 Minn. Laws 237, § 14.
13. 1997 Minn. Laws 237, § 15.

HealthEast Capitol Medical Laboratory

The Solution to Your Reference Laboratory Needs

Locally owned and operated

Accurate cost-effective testing
24 hours a day, 7 days a week

Technical consultant services

Continuing education seminars

Providing services to:
• physician office laboratories •
• long-term care facilities •
• group home •
• home health care agencies •

For more information, contact
CML Marketing at
(612) 232-3246

HealthEast Capitol Medical Laboratory
69 West Exchange Street
St. Paul, MN 55102-1004
Customer Service: (612) 232-3500

OFFICER ELECTIONS TAKE PLACE AT ANNUAL MEETING

The MMA Annual Meeting will take place at Madden's Resort in Brainerd, Sunday, September 14 through Tuesday, September 16. The slate of officer nominees is as follows:

President-elect:
Judith F. Shank, M.D.

Vice President:
Anthony C. Jaspers, M.D.

Secretary:
Robert Milligan, M.D.

Treasurer:
Noel R. Peterson, M.D.

Speaker of the House:
Blanton Bessinger, M.D.

Vice Speaker of the House:
Gary Hanovich, M.D.

AMA Delegates:
A. Stuart Hanson, M.D.*
Ben P. Owens, M.D.*
Andrew J. K. Smith, M.D.*

AMA Alternate Delegates:
Lyle Munneke, M.D.*
Thomas Peyla, M.D.*
Sally J. Trippel, M.D.

*Current delegation members eligible for reelection.

Nominations will remain open through the first session of the MMA House of Delegates.

• • •

CORRECTION

The Minnesota delegation to the American Medical Association House of Delegates did not agree to vote against the AMA report favoring a ban on intact dilation and extraction. Delegates voted as individuals on this controversial issue.

The Monitor
NEWS FOR MINNESOTA PHYSICIANS

Managed Care among Issues for MMA Annual Meeting

When the MMA House of Delegates convenes at Madden's Resort in Brainerd September 14, it will consider a host of challenging resolutions, including several dealing with managed care, end-of-life, and public health issues.

A number of resolutions point to physician frustration with problems raised by managed care arrangements and call on the MMA to take action. Delegates will decide these questions:

- Should the MMA urge health plans to avoid underpricing their products to such an extent that they are later forced to reduce services, cut benefits, or limit enrollees' access to care?
- Should the MMA seek legislation that increases the liability of health care plans?
- Should the MMA convene a task force to study and develop policy recommendations regarding financial incentives or disincentives to use particular treatments or medicines?
- Should the MMA set up a hotline system for members to report inappropriate influence by third-party payers on their clinical decision-making?

Some resolutions call on the MMA to take an active role in negotiating on behalf of physicians, or to educate physicians about contracts with health care organizations. Delegates will decide:

- Should the MMA educate physicians about ways to negotiate contracts that will minimize the damaging effects on their practices and on their patients of no-compete clauses?
- Should the MMA work with the AMA to modify antitrust laws and permit physicians to form coalitions that would negotiate fees and other conditions of contracts between physicians and health plans?

In a year that saw heightened media coverage of end-of-life issues—and the U.S. Supreme Court's ruling that Americans do not have a constitutional right to physician-assisted suicide—a half-dozen resolutions dealing with appropriate end-of-life support and palliative care were submitted.

Several resolutions call on the MMA to take the lead on public health issues such as promoting the effective management of strokes, raising awareness of the need for appropriate antimicrobial prescribing practices, and working with the Minnesota Department of Health to design a Center for Emerging Infectious Diseases.

For a summary of the resolutions that were submitted by press time, see pages 37 to 40.

The Gay Nineties Quartet from Montevideo, Minnesota, will bring music and deadpan comedy to the Annual Meeting. The barbershop quartet, also called "Four Fugitives from a Mortuary," has performed over 5,000 shows in 54 years. The quartet's motto is "Never won a contest, never lost a show," and their routine features a 160-year-old rocking melodeon. • • • • •



Viewpoint

Raymond G. Christensen, M.D.
President, Minnesota Medical Association

Physicians Have a Debt to Society

As my term as president of the Minnesota Medical Association comes to an end and I enter my 26th year of practice, I realize how much I enjoy the practice of medicine and what a great profession you and I have chosen.

Society extends to physicians great trust and privilege. From our selection as medical school students through our entire professional and personal lives, we enjoy a unique status in society. The expense of medical education is, to a large extent, borne by society. Financial aid, loans, and loan forgiveness opportunities are provided, making the ability to become a physician open to all who qualify.

Medical licensure—the privilege to practice—is granted by society and governed by the laws of our state. Hospitals, universities, and other facilities are provided for our use. We are obligated to perpetuate and expand the core of knowledge that defines our profession. We are also responsible for the education of our disciples, not only in the science, but also in the art and caring inherent in our work.

As physicians, we must continue to assume responsibility for the business of medicine. We are the professionals best trained in the needs and delivery of health care. As advocates for our patients and for our profession, we are called upon to develop health care policy and to interact with our local, state, and national governments. I try never to forget who my employer is—my patient. No matter where the paycheck comes from, no matter how many interlopers and agents try to shatter the doctor/patient relationship, the vital contract is still between the physician and patient. This contract has never been more necessary than it is today.

This year we have worked together to achieve the MMA mission "to develop and maintain an environment where physicians can deliver appropriate patient care and promote the public health." We continued our anti-violence endeavors and worked with the AMA and the attorney general to reduce media violence. Our efforts had a positive impact on the proposed national TV rating system. With other members of the Smoke-Free 2000 Coalition, we persuaded the Legislature to pass a strong bill aimed at deterring tobacco use, especially by children.

We helped steer the AMA toward a tougher stance on the proposed tobacco settlement, which in turn will affect the way Congress and the President decide to deal with the tobacco companies. We convinced legislators to reduce the 2 percent tax, and to repeal the $400 surcharge on physicians' medical licenses. We supported expanding MinnesotaCare coverage for adults without children to 175 percent of the federal poverty level. Other MMA successes include patient protections, repeal of growth limits, and the reinstatement of the ban on exclusive contracts.

Our success is the result of hard work by many committed people: task force and committee members and chairs, officers and trustees, who poured many hours and immeasurable energy into their roles, and by individual physicians—the very heart of the MMA—whose needs and interests our association exists to serve. This association is represented by truly magnificent individuals. I would like to thank the MMA staff for excellent, continuing support for the committees as well as for other MMA activities.

In closing, we must not forget to care for ourselves. To be creative advocates for our patients and for the public health, we must keep our own lives in balance. Today our contract with our patients includes the promise of balance in our personal lives while ensuring that care delivery systems are in place to meet our patients' emerging and ongoing needs.

Fellow physicians, we have a contract with our patients and a debt to society. In hiring us, our patients expect not only competent medical care in accessible surroundings, but our involvement in our local and greater community. We must not forget that if we honor our contract with our patients, society will honor us.

In our busy world, much is left undone. So it is with my work on your behalf as president of the MMA this past year. The MMA will continue efforts to ensure appropriate, broad-based funding of the MinnesotaCare program, to advance public health, and to step up our anti-violence and anti-tobacco initiatives. Other concerns loom on the horizon, such as long-term care and funding for medical education.

Thank you all—each and every member—for this opportunity to serve as your president. I have done my best, have made my mistakes, and have had my successes, always with your best interests at heart.

Good health and safe journeys.

Medicare Changes: Fairer Payments, Delay in Practice Expenses

Among the major changes to Medicare in the federal budget bill—which calls for $115 billion in cuts to the program—are revisions that will mean a fairer payment system for most Minnesota seniors.

Monthly Medicare AAPCC (adjusted average per capita cost) payments are currently less than $350 per senior citizen in 75 of Minnesota's 87 counties; under the new legislation, a payment floor is set at $367 in 1998 and would be updated annually. Rates would also be "blended" to reflect a 50/50 split between local and national costs by 2003. These provisions represent victories for the Geographic Coalition, a nonpartisan, MMA-led group of state medical associations that has worked for a more equitable payment system.

The bill also dictates that funds intended for graduate medical education (GME) be removed from the AAPCC rates, and instead be paid directly to health care facilities. However, disproportionate share (DSH) funds will remain with managed care payments.

Of the $115 billion in Medicare spending cuts over five years, about $100 billion is expected to come from providers. The reductions are estimated to extend the life of the Medicare trust fund by 10 years.

Implementation of the controversial resource-based practice expense RVUs will be delayed one year (until 1999) and then phased in over four years. Starting in January 1998, a single conversion factor of $37.13 will apply to all services. This conversion factor represents a 9.3 percent reduction for surgical services, a 3.8 percent increase for primary care, and a 9.7 increase for other nonsurgical services over the 1997 conversion factors. Updates to the new conversion factor will be based on a "sustainable growth rate" that is tied to changes in gross domestic product, rather than based on historical volume and intensity of physician services as measured through the volume performance standard.

New Medicare+Choice

The bill establishes a new Medicare Part C (Medicare+Choice) program to allow greater beneficiary choice. Beneficiaries will be able to choose either traditional Medicare fee-for-service, or a Medicare+Choice plan that could be organized as follows: 1) coordinated care plans (HMOs, PPOs, etc.); 2) provider-sponsored organization (PSO) plans; 3) private fee-for-service plans; 4) MSA product. PSOs entering the Medicare market must be licensed under state law as a risk-bearing entity, but may apply for a one-time, three-year federal waiver of state licensing requirements based on certain standards.

Other significant features of the bill include expanded preventive health services, such as annual mammograms for women 40 and older and annual prostate cancer screening tests for men 50 and older. The legislation also makes initial changes in graduate medical education financing, but long-term recommendations on GME are delayed pending further study. Two controversial provisions—to limit Medicare subsidies provided to wealthy beneficiaries (means-testing) and to increase the age of eligibility to 67—were dropped from the final compromise.

Health Coverage for Kids

MMA analysts and others are studying the sweeping budget legislation, which includes a provision to create state block grants for children's health insurance. That plan could have unintentionally punitive consequences for Minnesota, which has worked for years to provide health coverage for children under MinnesotaCare.

Mary Kennedy, who is Medicaid director for the Minnesota Department of Human Services, said although the state has been getting matching federal funds for MinnesotaCare, it could miss out on as much as $26 million annually in the next three years under this new provision. In trying to prevent some states from using the money for purposes other than expanding health coverage for children, Congress wrote stringent rules that may cut Minnesota—which already offers coverage for children up to 275 percent of federal poverty guidelines—out of the loop.

Kennedy said that the money could be used on outreach efforts to enroll the 60,000 to 70,000 Minnesota children who are still not signed up for MinnesotaCare. "And we can look at other children's health needs—mental health, school-based health programs," she added. The department is still analyzing the legislation and looking for ways to help secure Minnesota's share of the federal funding. • • • • •

MMA Supports Pay Raise

In a special session August 19, the Legislature approved pay increases for state health department officials, whose salaries had stagnated for a decade. The MMA applauded the overdue salary hikes, which are expected to help retain first-rate public health professionals in state government. Top department heads currently earning $78,500 will get a boost to $102,257. State epidemiologist Michael Osterholm, whose own salary was not at issue, had announced in June that he would leave Minnesota unless the raises were approved. Before the special session, Timothy J. Crimmins, M.D., chair of the MMA Board of Trustees, wrote a letter to the editor of the *Saint Paul Pioneer Press* urging passage of the pay increases. • • • • •

ANNOUNCEMENTS

Documentation of Health Plan Gag Policies Sought

Working with numerous state and regional medical societies, the American Medical Association (AMA) last year established a data bank with information concerning health plan practices, such as gag clauses and denials in authorization for care, that pose quality or ethical concerns to patients and physicians. Though many health plans have taken steps to make gag policies—which chill the ability of physicians to give complete information to patients so they can give informed consent—a relic of the past, the AMA has uncovered continuing examples of serious gag problems. Examples include two recent contract provisions in Colorado and Kentucky.

The AMA is asking for renewed support in gathering any information regarding gag policies or other unethical or clinically inappropriate practices. If you have contracts, letters, bulletins, or other relevant communications, please share them by fax or E-mail with either of the following AMA attorneys:

Evamarie Norey, J.D.
Health Law Division
American Medical Association
312/464-4835 (phone)
312/464-5846 (fax)
Evamarie_Norey@ama-assn.org

Carol O'Brien, J.D.
Health Law Division
American Medical Association
312/464-4367 (phone)
312/464-5846 (fax)
Carol_Obrien@ama-assn.org

Franks Leaving Minnesota

Ronald D. Franks, M.D., is leaving his position as dean of the School of Medicine at the University of Minnesota–Duluth to serve as dean of the James H. Quillen College of Medicine and vice president for health affairs at East Tennessee State University. Franks helped spearhead development of the Minnesota Rural Health School to establish a team of health care professionals in rural Minnesota; under his leadership, the University of Minnesota–Duluth School of Medicine has been nationally recognized for producing excellent rural physicians. Ron Ziegler, professor of medical microbiology and immunology and associate dean for academic and curricular affairs at the University of Minnesota–Duluth, has been named interim dean of the School of Medicine effective September 1.

HTAC Reports on HIV Testing of Pregnant Women

The Health Technology Advisory Committee (HTAC) has issued a report recommending voluntary HIV testing of pregnant women.

The report concurs with the Minnesota Medical Association position, adopted in 1995: The MMA supports routine offering of the HIV test by Minnesota physicians to all pregnant women in their care. A policy of offering HIV screening on a voluntary basis to pregnant women is also in line with recommendations by the Centers for Disease Control and Prevention and by the Minnesota Department of Health.

The goal of counseling pregnant women regarding HIV infection and making HIV testing available is to decrease the risk of maternal-infant transmission. Drug therapy during and after pregnancy can cut the odds of transmission from 25.5 percent to 8.3 percent, according to a public health report in the February 1997 issue of *Minnesota Medicine*.

HTAC's report stresses the importance of adequate follow-up care and services for HIV-positive mothers and their infants—including the most appropriate treatment regimen and post-test counseling. The report also recommends that prevention information be provided to women who test HIV-negative.

Grant Will Help Ada Rebuild Bridges Medical Services

Three Minnesota communities will receive funding through the Community Health Center Grant Program, designed to help establish new community-owned and operated health centers. They are: Bridges Medical Services, Ada; the Leech Lake Tribal Council's Ball Club Community Health Center, Ball Club; and McGregor Area Clinic, McGregor. The program is administered by the Minnesota Department of Health's Office of Rural Health and Primary Care, which helps communities maintain and/or improve access to health care. The MMA worked with the Office of Rural Health and Primary Care to direct funding to Bridges Medical Services, which was severely damaged by the spring floods.

New Form Required for USDOT Medical Exams

All medical providers conducting the U.S. Department of Transportation physical exam must use a new form and wallet card. The new forms can be obtained from the Minnesota Trucking Association, 2515 Wabash Avenue, Suite 150, St. Paul, MN 55114. The association's phone number is 612/646-7351. Both the new form and the card now have three check boxes, to indicate whether the driver is considered medically qualified due to a federal waiver, a state waiver, or is exempt from medical qualifications while driving in an exempt intra-city zone. Physicians and clinics should discard any old forms that do not include this information; the new forms were required starting March 1, 1997.

House Prepares to Discuss, Debate Resolutions

The 1997 Minnesota Medical Association House of Delegates will convene at Madden's Resort in Brainerd on Monday, September 15, and Tuesday, September 16, to take action on resolutions that will set the MMA's course for the coming year. As *The Monitor* goes to press, the following draft resolutions have been submitted:

Res. 100, Promotion of the Physician's Guide to Hospice Care (MN Hospice Organization)

Introduced by the Medicine, Religion, and Bioethics Committee, Zumbro Valley Medical Society (ZVMS)

Resolves that the MMA provide funding to make "The Physician's Guide to Hospice Care," by the Minnesota Hospice Association, available to all licensed physicians, discharge planners, and hospitals in Minnesota.

Res. 101, MMAA Support

Introduced by the ZVMS

Resolves that the MMA commend the members of the Minnesota Medical Association Alliance (MMAA) for their outstanding efforts and work, and for the ongoing support of the medical profession, and further resolves that the MMA continue to provide future financial support of the MMAA.

Res. 102, Funding for the MMAA

Introduced by Stearns-Benton Medical Society (SBMS)

Resolves that the MMA rescind the section of the 1997 MMA budget that eliminates funding for the MMAA, and further resolves that MMA funding for administrative support of the MMAA be permanently restored.

Res. 103, MMA Annual Meeting Content, Structure, and Format

Introduced by the Ramsey Medical Society (RMS)

Resolves that the MMA appoint an Annual Meeting Task Force of physician members to make recommendations to the MMA Board of Trustees on the future content, structure, and format of the annual meeting, and that the task force consider the need of members' involvement in the annual meeting, as well as educational offerings in areas including leadership development, communication skills, interpersonal relationship development, continuing medical education sessions, and industrial exhibits.

Res. 104, Restore Funding for MMAA Administrative Support

Introduced by RMS

Resolves that the House of Delegates rescind the section of the 1997 MMA budget that eliminates funding for the MMAA, and further resolves that funding of the MMAA by the MMA be permanently restored to reflect the importance and significance of the MMAA's membership and activities.

Res. 105, Support for Ongoing Alliance Funding

Introduced by the Hennepin Medical Society (HMS)

Resolves that the MMA continue its administrative support of the Minnesota Medical Association Alliance in an amount of approximately $20,000 per year so that the work of the Alliance and its members may continue.

Res. 106, Alliance Funding

Introduced by the MMA Board of Trustees

Resolves that the MMA and MMAA investigate possible further joint activities through a study task force, that the MMA assist the MMAA in developing and implementing a membership recruitment and retention marketing campaign, and that the two organizations examine various factors to determine an appropriate conversion factor for financial support of the MMAA by the MMA. Further resolves that for MMAA fiscal year 1997 the conversion factor will be $17.50, making a total MMA contribution of $18,165.

Res. 107, Support of Human Rights and Freedom

Introduced by the Committee on Minority Affairs

Resolves that the MMA affirm AMA policy stating, "Continued Support of Human Rights and Freedom: The AMA continues 1) to support the dignity of the individual, human rights and the sanctity of human life, and 2) to oppose any discrimination based on an individual's sex, sexual orientation, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies." It further resolves that MMA encourages physicians to take leadership roles in their communities to eradicate racial, sexual, and religious discrimination.

Res. 200, Provider Tax Itemization and Appeal Process

Introduced by the RMS

Resolves that the provider tax be labeled an "access tax" and be itemized on all bills and payments as such, and that the MMA widely publicize information to physicians explaining the process of appealing cases in which payers are not itemizing the provider tax in payments, and urge all MMA members to appeal at least one case in their practice in which the tax is not itemized.

Res. 201, Commission on Financing Medical Education

Introduced by the RMS, HMS, Lake Superior Medical Society (LSMS), SBMS, ZVMS

Resolves that the MMA, on behalf of Minnesota physicians and citizens, take a leadership role in identifying and implementing new strategies designed to ensure a long-term, stable financing base for medical education in this state, and that the MMA help establish a broad-based commission for the purpose of developing consensus within the com-

Resolutions continued on page 38

Resolutions *continued from page 37*

munity on a financing proposal for medical education that can be presented to the Legislature and the governor's office. It further resolves that a preliminary report of this commission be available for review by MMA members and trustees preferably by January 1, 1998, but no later than July 1, 1998.

Res. 202, Uniform Credentialing Process

RMS, HMS

Resolves that the Minnesota Medical Association convene a task force comprising appropriate stakeholders, including representatives of the Minnesota Council of Health Plans, the Minnesota Hospital and Healthcare Partnership, the Medical Credentialing Services of Minnesota, and any other appropriate associations, to develop or expand the existing uniform credentialing and verification process for implementation by January 1, 1999, and to evaluate whether to pattern the process on, or link it with, the American Medical Accreditation Program.

Res. 203, Physician Prescription/Formulary Restrictions

HMS, Minnesota Psychiatric Society

Resolves that the MMA convene a task force to conduct an in-depth study of a health organization's financial incentives or disincentives to physicians to direct the use or nonuse of a particular medicine or treatment, and that based on the finding of the task force, the MMA develop appropriate policy statements concerning these issues.

Res. 204, Clinical Information Systems

SBMS

Resolves that the MMA, with due membership input, consideration, and planning, seek approval from appropriate state and federal legislative bodies for a program offering substantial financial benefits and incentives for medical practitioners, clinics, and other points of care to acquire and develop individual technologic solutions leading to an ultimately less expensive, higher quality, and better coordinated global clinical information infrastructure for Minnesota. It further resolves that a preliminary report of recommendations for such a program be available to MMA members by January 15, 1998.

Res. 205, Raise the Legal Age for Use of Tobacco Products

J.P. Abenstein, M.D., Delegate, ZVMS

Resolves that the MMA, through its delegation to the American Medical Association, work with Congress to limit the sale of tobacco products to commercial outlets that hold liquor licenses, and further resolves that the MMA explore the possibility of pursuing similar legislation at the state level.

Res. 206, Immunization Registry Authorization Legislation

Barbara Yawn, M.D., Delegate, ZVMS

Resolves that the MMA make passage of the immunization registry authorization legislation a high priority, and educate members regarding the benefits, potential risks, and patient confidentiality concerns of an immunization registry.

Res. 207, Legislation Providing for Health Plan Liability

RMS

Resolves that the MMA review the state law dealing with the liability of health care plans that was enacted by the Texas State Legislature and signed into law by the governor of Texas, and that the MMA support the introduction and passage of a similar law in Minnesota.

Res. 300, Acute Mental Illness

Upper Mississippi Medical Society (UMMS)

Resolves that the MMA work with the Minnesota Department of Human Services to accomplish rule changes that reflect the reality of treating acute mental illness in the rural setting, and thus allow appropriate inpatient treatment for such patients when an outpatient alternative is not available. It further resolves that if attempts to work with MDHS in rule revision are unsuccessful, the MMA pursue legislation requiring such changes.

Res. 301, Motorcycle Safety Devices

LSMS

Resolves that the MMA pursue legislation to require motorcycles to carry additional warning devices to enhance their visibility, and further resolves that the Minnesota delegation to the AMA pursue this legislation nationally.

Res. 302, Birth Defects Information System

Virginia Lupo, M.D., Delegate

Resolves that the MMA support implementation of the Birth Defects Information System at the legislative level, recognizing the overwhelming importance of strict patient confidentiality and the need for research and monitoring of the birth defects occurring within the state.

Res. 303, Seat Belt Safety

Range Medical Society (RanMS)

Resolves that the MMA support legislation that would increase the fine to $100 for the first offense and $200 for the second offense, and treat all seat belt violations as a moving violation and as a primary offense.

Res. 304, Protective Headgear for Minors While Riding ATVs and Snowmobiles

RanMS

Resolves that the MMA encourage the Legislature to require the use of protective headgear by minors while operating bicycles, ATVs, and snowmobiles.

Res. 305, Use of Personal Flotation Devices by Minors

RanMS

Resolves that the MMA support legislation mandating the wearing of personal flotation devices by minors in navigable waters in the state of Minnesota with the exception of those

embarked underway on licensed commercial watercraft complying with U.S. Coast Guard standards.

Res. 306, Separate CPT Code
RanMS

Resolves that the MMA recommend to the American Medical Association CPT Editorial Board that a separate CPT code for medical and surgical encounters performed by physician assistants and nurse practitioners be developed.

Res. 307, Tobacco Control Settlement
RMS

Resolves that the MMA commend Attorney General Hubert Humphrey for his vigilance in protecting citizens' rights as evidenced by the Minnesota suit against the tobacco companies and during the settlement negotiations with the tobacco companies, and further resolves that the MMA urge Congress to proceed with caution and include in legislation the seven provisions outlined in the MMA-introduced resolution adopted by the AMA House of Delegates.

Res. 308, Eliminating Delayed Payments by Third-Party Payers
RMS

Resolves that the Minnesota Medical Association survey physician members to determine whether health plans and managed care organizations are making timely payments to physicians as required by Minnesota state law. It further resolves that should the MMA Board of Trustees determine that delayed payments are a problem for physicians, the MMA will draft and support legislation in Minnesota, based on the successful Maryland law, to eliminate the problem of delayed payments by third-party payers to physicians.

Res. 309, Physician Contract Education Program
RMS

Resolves that the MMA work with the Minneota Medical Group Management Association and other interested stakeholders to develop an educational program for physicians that addresses common elements found in managed care/physician contracts, and that assists physicians' understanding of those elements. Further resolves that the MMA develop a model contract that includes standard provisions to use as reference in individual contract negotiations, and that the MMA consider developing a contract alert program to inform members on issues related to negotiations with managed care organizations.

Res. 310, The Erosion of Medical Decision-Making by Physicians
RMS

Resolves that the MMA establish, in conjunction with component medical societies, a "hotline" system for member physicians to report inappropriate influence on their clinical decision-making by third-party payers or health plans when they advocate for their patients by recommending options that they believe are in the best interest of the patients, and that the MMA take whatever actions it deems appropriate on behalf of these physicians. It further resolves that the MMA develop a dispute mechanism to be used by third-party payers when denial of requested medical care occurs with the use of an independent third party, and that the decision of treatment be based on acceptable professional standards for the medical care that is requested.

Res. 311, Stroke Awareness
HMS

Resolves that the MMA help create and lead a statewide effort by a coalition of relevant primary care and subspecialty groups, public service organizations, health care organizations, health care systems, and governmental agencies to plan and implement public and provider education programs to increase the number of patients presenting for care early and extend the rapid medical response to stroke throughout the state. It further resolves that the MMA convene an ad hoc group to implement strategies for promoting efficient and effective management of ischemic stroke from onset through acute hospitalization, rehabilitation, and reintegration into the community, and that the MMA, through its delegation to the AMA, help institute a similar program nationally.

Res. 312, Anti-Microbial Prescribing Practices
HMS

Resolves that the MMA work to improve physician, patient, and community awareness of the need for appropriate anti-microbial prescribing practices. To this end, the MMA should form a task force consisting of representatives of Minnesota Council of Health Plans, the Minnesota Hospital and Healthcare Partnership, the Minnesota Department of Health, and other appropriate professional associations, including media and communications professionals, to develop an education and communication plan for the MMA Board of Trustees' consideration within one year of the resolution's adoption.

Res. 313, Center for Emerging Infectious Diseases
HMS

Resolves that the MMA support the notion of a soundly designed Center for Emerging Infectious Diseases, and work with representatives of the Minnesota Department of Health's Acute Disease Epidemiology Division to plan and design such a center.

Res. 314, Minnesota Health Care Coalition on Violence
HMS

Resolves that the MMA support the work of the Minnesota Healthcare Coalition on Violence and its task forces, especially by helping to promote statewide educational programs for health care professionals.

Res. 315, Personality Disorders and Disability Act
HMS

Resolves that the MMA Board of Trustees study and develop a position paper on whether personality disorders constitute "disability" under the Americans with Disabilities Act (ADA).

Resolutions continued on page 40

Resolutions *continued from page 39*

Res. 316, Appropriate Pricing of Health Plan Products

HMS

Resolves that the MMA urge health plans to avoid underpricing their products in order to achieve larger market share to such an extent that they are later forced to reduce services, cut benefits, or limit access to care for their enrollees. It further resolves that whenever health plans determine that costs must be cut, direct patient care costs should be the last to be cut, and that the MMA convene a forum of health plan representatives, state regulators, and physicians to facilitate communication on the difficult issues related to the relationship between quality care and cost containment.

Res. 318, "No Compete" Clauses

David Moen, M.D., Delegate, East Central Medical Society

Resolves that the MMA educate physicians about the possible damaging effects that "no compete clauses" may have on their practices and on their patients, and about ways to effectively negotiate contracts with health care organizations that minimize any such damaging effects. It further resolves that the MMA—through existing and future communication mechanisms—continue to discuss with health plan leadership concerns regarding potential impact of "no compete clauses" on physicians' practices and on their patients.

Res. 400, Nursing Home Nurses Caring for Patients in Adjacent Facilities

LSMS

Resolves that the MMA support legislation or rulemaking by the Minnesota Department of Health that would allow nursing home staff to offer care to residents of senior nursing facilities adjacent to nursing homes without further regulation or license requirements by the apartment facility, beyond that already required for care delivery in a nursing home.

Res. 402, Emergency Financial Assistance Near/At End of Life

Medicine, Religion, and Bioethics Committee, ZVMS

Resolves that the MMA join with the Minnesota Hospice Organization to co-recommend that the state of Minnesota explore the provision of emergency relief assistance to licensed hospice programs in the event of a catastrophic depletion of funds.

Res. 403, Physician Education Re: Pain Control and Management

Medicine, Religion, and Bioethics Committee, ZVMS

Resolves that the MMA sponsor a statewide initiative for physician education on pain management in terminal care.

Res. 404, "Mandate" for Appropriate End-of-Life Emotional/ Spiritual Support

Medicine, Religion, and Bioethics Committee, ZVMS

Resolves that the MMA recommend establishment of community-based consortiums designed to improve the quality of palliative care for persons who are dying.

Res. 405, Use of Current Mechanisms to Direct Care (Advance Directives)

Medicine, Religion, and Bioethics Committee, ZVMS

Resolves that the MMA recommend the dissemination of information about advance directives in the local community by local medical societies.

Res. 406, Palliative Medicine Education

Medicine, Religion and Bioethics Committee, ZVMS

Resolves that the MMA recommend that graduate medical education programs and continuing medical education programs in Minnesota include a formal palliative care component.

Res. 407, Protect Prescriber from Fraudulent Use of DEA Number

RMS

Resolves that the MMA work with the AMA to introduce state and federal legislation to outlaw the practice of requiring Drug Enforcement Agency (DEA) numbers for noncontrolled substance prescriptions, and outlaw the sale or release of DEA number data to nongovernmental entities, and outlaw the use of DEA numbers to track prescription histories of physicians for commercial use.

Res. 408, Antitrust Laws and Physician Negotiation with Health Plans

RMS

Resolves that the MMA develop a campaign to promote the concept that antitrust laws not be applicable to (1) the negotiations between health care professionals and a managed care entity regarding fees for services, withholds, incentives, and other terms and conditions of a managed care contract, and (2) the physician's ability to implement such terms and conditions. It further resolves that the MMA work with the AMA to support legislation that would modify antitrust laws to permit physicians to form "health care professionals coalitions" for the purposes of negotiating terms of contracts between physicians and health care plans. • • • • •

The Monitor
SEPTEMBER 1997
• • •
PRESIDENT
Raymond G. Christensen, M.D.
CHAIR, BOARD OF TRUSTEES
Timothy J. Crimmins, M.D.
CHIEF EXECUTIVE OFFICER
Paul S. Sanders, M.D.
EDITOR
Lorrie Holmgren
WRITER
Susan Maas
• • •

University of Maryland Baltimore

A Buying and Leasing Program With Special Benefits

- One stop shopping by FAX
- Buy or lease
- Choose any make or model
- Car or truck
- New or used
- Save time
- Save money
- Eliminate shopping frustration

PHYSICIAN APPROVED MMBR ASSOCIATION ENDORSED

Remember, whether you purchase or lease, MMBR Motor Services and Creative Leasing, Inc. will help you get the most vehicle at the best price. We'll even help you sell your old auto.

Use your money wisely. For personal attention and lease or purchase information on any vehicle, call 612/623-2860, or toll-free 800/298-MMBR.

MMBR Motor Services is a service of Minnesota Medical Business Resources, a physician-owned corporation of your medical association.

New Vehicle Leases**

Make/Model	MSRP	Your Price*	24 Mo	36 Mo	48 Mo	60 Mo
97 GMC Jimmy SLS 4dr	$27,072	**$24,904**	$422	$376	$353	$331
97 Ford Explorer XLT 4dr	$28,880	**$26,025**	$462	$415	$373	$350
97 Nissan Pathfinder SE	$30,618	**$28,268**	$484	$407	$398	$366
97 GMC Yukon SLE 4dr	$32,999	**$31,327**	$561	$447	$412	$379
97 Chevrolet Tahoe LS 4dr	$32,935	**$31,270**	$560	$447	$411	$379
97 Chevrolet Suburban 1/2 LS	$36,457	**$34,293**	$621	$515	$471	$434
97 Toyota 4-Runner SR5 4dr	$31,643	**$30,305**	$579	$477	$417	$384
97 Mitsubishi Montero LS 4dr	$31,690	**$30,361**	$516	$446	$467	$424
97 Ford Expedition XLT 4dr	$33,845	**$31,159**	$462	$401	$379	$361

* Sale price before tax, license, license fees, and 1997 price increase.
** All lease payments listed above are monthly lease payments before tax on factory ordered leases. These lease payments are based on a $0.00 cap reduction and 15,000 miles/year. The only moneys needed to start the above leases are first payment, security deposit, and license for the first year.



MMBR

MOTOR SERVICES

MINNESOTA MEDICAL BUSINESS RESOURCES

OWNED BY MMA & HMS

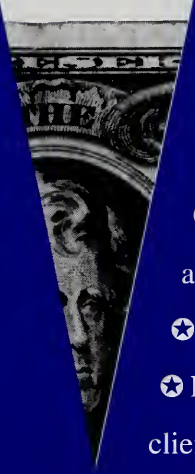
DID YOU KNOW THAT MMBR'S EMPLOYEE BENEFITS TEAM CAN HELP YOU

B R I D G E

THE GAP

Did you know that MMBR, the resource company owned by the Minnesota Medical Association and Hennepin Medical Society, can really help you with the challenges of providing employee benefits?

That's right. Because providing services to medical professionals is our only specialty, you can be sure that MMBR will do a great job in helping you design and obtain quality benefit plans for your practice.



Join the many other medical practices who count on MMBR for employee benefit plans such as:

- ✪ Group medical, dental, disability and life coverage
- ✪ Qualified retirement plans
- ✪ Educational personal finance seminars for your employees
- ✪ Personal financial reviews for physicians and staff
- ✪ Voluntary benefits such as life, disability, and long term care insurance
- ✪ Payroll deduction auto and home insurance
- ✪ Free COBRA administration for MMBR group clients

We work to make bridging the gap convenient and cost effective.

Call Barry Weber or Dan Hagberg today at

800-298-6627

MMBR

Minnesota Medical Business Resources
Owned By MMA & HMS

Mount Sinai Remembered

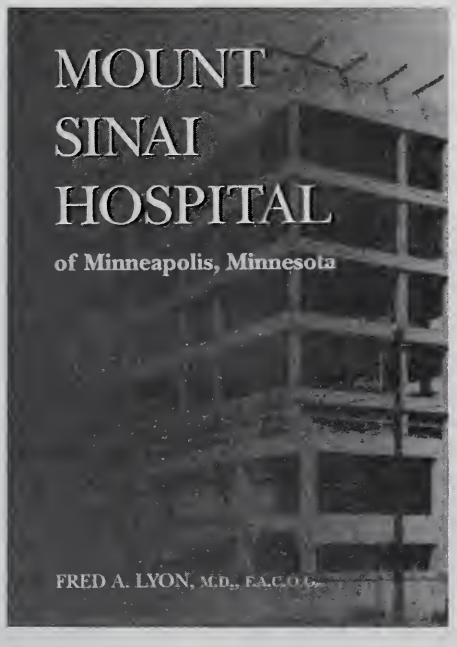
In "Mount Sinai Hospital of Minneapolis, Minnesota: A History," Fred Lyon, M.D., F.A.C.O.G., tells the story of a hospital founded in response to discrimination against Jewish physicians.

Reviewed by Burton S. Schwartz, M.D., F.A.C.P.

I was chief of staff at Mount Sinai Hospital in Minneapolis in 1987, when discussions began about merging Mount Sinai and Metropolitan Medical Center. It took awhile for me and others at Mount Sinai to realize that the hospital could not survive as an independent entity. We approached the merger with both hope and sadness: hope that the spirit of Mount Sinai could be preserved, and sadness about the loss of an important community institution. Metropolitan-Mount Sinai eventually had to close as well, which occasioned even greater sadness for a number of communities.

Dr. Fred Lyon has captured the hospital's history and uniqueness in his book "Mount Sinai Hospital of Minneapolis, Minnesota: A History," published in 1996 by the Mount Sinai History Committee. It is a wonderful book, not only for those of us who were part of Mount Sinai, but also for people who never even set foot in the hospital.

Mount Sinai was founded in 1949-50 in response to prejudice against Jewish physicians and patients in the Minneapolis/St. Paul area. The first part of the book, contributed in part by Jane Tang, Ph.D., formerly of the University of Minnesota Medical History Department, discusses anti-Semitism in the United States and Twin Cities in the 1940s and before. Jewish physicians could not get on staff at hospitals in Minneapolis and St. Paul; training programs did not provide them the training necessary



to become board certified in their specialties. This background provides a context for understanding the need for a Jewish hospital.

Dr. Lyon, a retired Minneapolis obstetrician and gynecologist, begins by describing the fundraising efforts to build the new hospital. He properly credits philanthropist Jay Phillips for his moral and financial leadership; however, many other people, both within and outside the Jewish community, also contributed. The book traces the hospital from its beginning through its maturity and, finally, its demise. Mount Sinai welcomed all patients and physicians, and its nursing department was notably strong. The auxiliary played a major role in fundraising and sponsoring community events. The hospital did have problems, however. It appeared to attract mostly specialists, especially in internal medicine. It lacked primary care, which was one of the reasons it eventually faltered.

Dr. Lyon also discusses the impact of major changes in the health care business, such as HMOs and shorter hospital stays, which contributed to a surplus of hospital beds in the Twin Cities area. Small hospitals, most vulnerable to marketplace pressures, could not compete; Eitel and Mount Sinai were among the first to close.

Later chapters address various hospital departments and were written by individuals who had significant roles in those departments. The book also includes an excellent bibliography related to anti-Semitism nationally and locally.

Fortunately, the reasons Mount Sinai was formed are not apparent today. Jewish physicians can practice at any hospital, and Jewish patients do not face discrimination. But Lyon's history serves as a reminder of a time when that was not true and as a tribute to patient care and education. Through this book, the spirit of Mount Sinai lives on in the community.

Dr. Lyon, along with Dr. Arnold Kremen and the Mount Sinai History Committee, chaired by Dr. Reuben Berman, should be commended for revitalizing that spirit. MM

Burton Schwartz is president and medical director at Minnesota Oncology Hematology, P.A., in Minneapolis.

Affiliated
COMMUNITY
Medical Centers, P.A.

Join the security of a large multispecialty group located in Southwest and West Central Minnesota Communities of 3,700 to 19,000. All areas flourish with four-season recreational opportunities, strong economies and excellent education where family and lifestyle are a priority. Outstanding benefits for BE/BC physicians in:

Dermatology
Family Practice
Internal Medicine
Neurology
Ob-Gyn
Orthopedic Surgery

Contact: Janiece Durham
Physician Recruitment Coordinator
Affiliated Community Medical Centers
101 Willmar Avenue SW
Willmar, Minnesota 56201-3591
320-231-6366

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142

E-Mail: stephanie.l.jussila@qm.healthpartners.com

Central Minnesota
Group Health Plan
HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220



For 100 years, we've been creating new stories every day about our care for kids with chronic conditions.

Gillette Children's
Specialty Healthcare
An Essential Community Provider

Ellen's Story

Ellen was a good student in school, active with athletics, academics, friends and family. All that stopped when her chronic pain started — the migraines and severe muscle pain that medications couldn't relieve.

With the help of pediatric experts at Gillette Children's Specialty Healthcare, Ellen has learned to control her pain. And she has returned to her active life.

If your child has headaches, abdominal pain, trauma, musculoskeletal pain, phantom pain or pain secondary to illness, call for the Chronic Pain Program at Gillette.

For more information or a referral, call (612) 229-3851

- Cerebral palsy and other neuromotor delays
- Spina bifida
- Juvenile arthritis
- Brain and spinal cord injuries
- Epilepsy
- Complex orthopaedic conditions
- Chronic pain
- Technology dependency

A Tribute to
Cassius Marcellus Clay Ellis III, M.D.

December 21, 1936–May 15, 1997

By John S. Najarian, M.D.



John S. Najarian, M.D., delivered the following remarks at the funeral for Cassius Marcellus Clay Ellis III, M.D., on May 20, 1997. A 1962 graduate of the Meharry Medical College in Nashville, Tennessee, Ellis was a general and vascular surgeon; professor of surgery and assistant dean for minority affairs, University of Minnesota Medical School; director of surgical education, North Memorial Medical Center; Department of Surgery consultant, St. Paul-Ramsey Medical Center; consultant, Pilot City Health Center and Model Cities Health Center; and fellow of the American College of Surgeons and the International College of Surgeons. He is survived by his wife, Phyllis Hannah Ellis, sons, Thomas Scott and Clay Edward, daughters, Lynn Marie and Susan Elaine, father, James Scott Ellis Jr., sister, Mrs. Rose Anna Brown, and half-sister, Mrs. Sandra Davis.

Cassius Marcellus Clay Ellis III was true to his namesake—fellow Kentuckian Cassius Marcellus Clay, a very important early abolitionist. Cass made it his quest in life to support young African-American brothers and sisters, to help them reach their full potential, to be the best they could be. His most obvious effort was opening doors in health fields to minority students, but he was also involved in all social and economic areas of the black community.

I still recall the first day I met Cass. I was the new professor and chair of the Department of Surgery at the University of Minnesota in 1967. After one year, it became obvious that the excellent training program at the Minneapolis VA Hospital should be combined with the University of Minnesota program. With this integration, the residents in the VA program became our residents. Thus, in 1968, I first met Cass, who had been a resident in the VA training program. As soon as I saw him, I said to myself, "There goes a nose guard." As a former tackle, I established an immediate camaraderie

with him. When Cass was on my service and we operated together, we had a rule: We could not stand on the same side of the operative table.

It soon became obvious to me that Cass was not only an excellent surgeon and a caring physician, but also a superb teacher of residents and medical students. His was a God-given talent, and he used it effectively. When he finished his surgical training in 1970, Cass proceeded into private practice. I could not let this teaching talent go to waste, so I appointed him a clinical assistant professor. Thus, he would be teaching our residents and students. He first practiced at Mount Sinai Hospital in south Minneapolis and became the chief of our educational program there—a position he also held at Metropolitan Medical Center in downtown Minneapolis and eventually at North Memorial Medical Center in Robbinsdale. He was appointed the first assistant dean for minority students at the university's Medical School. In that capacity, he unselfishly spent many hours tutoring minority students so they could compete on a level plane with other medical students who had enjoyed educational advantages not often available to all minorities. Cass never forgot his roots.

It's 4am.
Time to find the job you want.
Unless, of course, you're too tired to lift a finger.

1·800·233·9330

Researching career opportunities takes time that you don't have. And often when you do, no one else is at work to help you. But the new **Practice Opportunity Line** offers an easy, no pressure, confidential way to conduct the search on your own, 24 hours a day. All you have to do is call, follow the prompts and research the openings. Then send a voice mail mini-resume to the opportunities you wish to pursue. It's fast. It's easy. And you're awake anyway.



The Practice Opportunity Line
We're on call for you.

He was one of our best teachers. A rotation on his surgical service was most sought after by our surgical residents and medical students. I often wonder why he made such an excellent teacher; I think it can be summed up in the following four ways. First, he knew all the students and residents: he knew their names, educational backgrounds, families, and personal lives. He cared about them, and it really showed. Second, he treated residents and students as colleagues. He showed respect for them. Third, he made teaching fun. On Tuesdays and Thursdays, he had a two-hour surgical problem-solving session. At his insistence, these sessions were always accompanied by food. Finally, at some time during the rotation, he would take his residents and students to lunch or dinner—just to sit down and discuss their personal and professional goals and aspirations.

Cass's primary passions were supporting the black community, caring for his patients, teaching students, and contributing his time and expertise to professional and charitable organizations. Yet he never forgot his family. He was an excellent husband to his No. 1 supporter: his beautiful wife, Phyllis. When her current illness became worse and restricted her activity, he continued to take her to professional meetings as well as on trips and vacations. He was always at her side when she needed him. In addition, he took time to attend softball games, academic events, music recitals, and other activities for all of his kids, Scott, Clay, Lynn, and Susan, all of whom subsequently graduated from college.

In my judgment, Cass was the best of his kind—humankind. I will never forget the first time he called me brother. So I'm here to say goodbye to my brother and my friend, Cass. You'll be so missed by so many. **MM**

John Najarian is a clinical professor of surgery with the University of Minnesota Department of Surgery.

Obituaries appear on pages 48-49.

OFFICE PRODUCTS AT PRICES THAT WILL MAKE YOU *gasp*

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED



We all need office supplies. The key is to find the vendor that carries everything you need at the best possible prices. MMBR has selected Office Depot as our endorsed office supply vendor. Through MMBR, you can save an average of *40 percent off* all general office supplies and furniture. MMBR has also arranged retail store pricing on *electronics, business machines, and software,* a special *Purchasing Card* to take advantage of volume discounts at 7 Twin Cities retail stores, and additional *frequent buyer discounts.* Ask about our *convenient billing options.* MMBR can put the immediate response of *Internet* and specialized software ordering at your fingertips, and *next day delivery* is standard with nearly all products. For personal attention and unparalleled service, call 623-2860, or toll free 800-298-MMBR (6627), and ask for our office supply program.

MMBR

OFFICE SUPPLY

MINNESOTA MEDICAL BUSINESS RESOURCES
OWNED BY MMA & HMS

In Memoriam

Clarence E. Arlander, M.D.
University of Minnesota, 1930
Born: 1905, Died: Jan. 12, 1997

Arnold M. Berg, M.D.
University of Minnesota, 1953
Born: 1920, Died: Dec. 7, 1996

Phil R. Berger, M.D.
Wake Forest University, 1945
Born: 1922, Died: Jan. 15, 1997

Eugene J. Birkemeyer, M.D.
University of Minnesota, 1961
Born: 1934, Died: June 1, 1997

Benjamin M. Black, M.D.
Stanford University, 1936
Born: 1910, Died: April 1, 1997

Paul Swenson Blake, M.D.
University of Minnesota, 1943
Born: 1919, Died: May 23, 1997

George J. Boody Jr., M.D.
University of Minnesota, 1934
Born: 1908, Died: Sept. 15, 1996

Robert N. Bowers, M.D.
University of Minnesota, 1940
Born: 1916, Died: March 2, 1997

Paul E. Brenk, M.D.
University of Minnesota, 1957
Born: 1929, Died: May 22, 1996

Henry A. Brown, M.D.
Virg. Commonwealth Univ., 1934
Born: 1907, Died: Feb. 16, 1997

Gerald E. Church, M.D.
University of Michigan, 1954
Born: 1927, Died: Feb. 24, 1997

Coleman J. Connolly, M.D.
University of Minnesota, 1943
Born: 1916, Died: Dec. 5, 1996

Gary A. Cowan, M.D.
University of Minnesota, 1962
Born: 1937, Died: Sept. 4, 1996

Robert C. Cowger, M.D.
University of Iowa, 1964
Born: 1932, Died: March 30, 1996

Robert J. Cumming, M.D.
University of Minnesota, 1961
Born: 1931, Died: Nov. 9, 1996

Guy W. Daugherty, M.D.
Virg. Commonwealth Univ., 1937
Born: 1912, Died: May 5, 1996

Curtis E. Davis, M.D.
Howard University, 1962
Born: 1935, Died: June 3, 1997

F. Edmund Donoghue, M.D.
Columbia University, 1940
Born: 1916, Died: April 6, 1997

Cassius M.C. Ellis III, M.D.
Mehary Medical College, 1962
Born: 1936, Died: May 15, 1997

John E. Faber, M.D.
University of Wisconsin, 1932
Born: 1908, Died: Aug. 5, 1996

Isadore Fisher, M.D.
University of Minnesota, 1936
Born: 1910, Died: March 28, 1996

Dean S. Fleming, M.D., M.P.H.
University of Minnesota, 1937
Born: 1911, Died: Jan. 1, 1997

Floyd K. Garetz, M.D.
University of Minnesota, 1955
Born: 1925, Died: Nov. 14, 1996

Irving Greenfield, M.D.
Temple University, 1939
Born: 1911, Died: June 12, 1997

John T. Hachiya, M.D.
University of Nebraska, 1979
Born: 1955, Died: Nov. 28, 1996

Harold B. Hanson, M.D.
Rush Medical College, 1930
Born: 1901, Died: Oct. 14, 1996

Lyle J. Hay, M.D.
University of Minnesota, 1938
Born: 1913, Died: Jan. 13, 1997

Olaf M. Heiberg, M.D.
University of Minnesota, 1935
Born: 1902, Died: March 3, 1997

John G. Heisel, M.D.
Medical College of Wisconsin, 1950
Born: 1921, Died: Aug. 1, 1996

David F. Hickok, M.D.
Harvard Medical School, 1956
Born: 1930, Died: June 10, 1996

Laurence D. Hilger, M.D.
University of Minnesota, 1937
Born: 1911, Died: July 5, 1997

Daniel R. Huff, M.D.
University of Minnesota, 1985
Born: 1958, Died: July 11, 1996

Mitchell J. Jurdy, M.D.
University of Minnesota, 1941
Born: 1904, Died: May 12, 1997

Roger E. Kelley, M.D.
University of Minnesota, 1952
Born: 1923, Died: Jan. 15, 1997

Erkki A. Leppo, M.D.
University of Helsinki, Finland, 1936
Born: 1909, Died: April 12, 1996

John C. Lillie, M.D.
University of Michigan, 1939
Born: 1915, Died: Nov. 30, 1996

Russell C. Lindgren, M.D.
University of Minnesota, 1932
Born: 1907, Died: Jan. 21, 1997

George B. Logan, M.D.
Harvard Medical School, 1934
Born: 1909, Died: June 7, 1997

William F. Mazzitello, M.D.
Medical College of Wisconsin, 1945
Born: 1920, Died: July 25, 1997

Thomas B. Merner, M.D.
University of West. Ontario, 1937
Born: 1912, Died: Dec. 7, 1996

Michael A. Messenger, M.D.
University of Illinois, 1963
Born: 1937, Died: Jan. 28, 1997

Nicholas J. Musty, M.D.
University of Minnesota, 1941
Born: 1906, Died: Nov. 17, 1996

C. Barton Nelson, M.D.
University of Minnesota, 1930
Born: 1905, Died: March 10, 1996

E. Theodore Palm, M.D.
University of Minnesota, 1946
Born: 1922, Died: Dec. 22, 1996

John Hartley Peterson, M.D.
University of Minnesota, 1933
Born: 1908, Died: Aug. 4, 1997

Kurt Pollak, M.D.
University of Minnesota, 1952
Born: 1921, Died: April 29, 1997

Andrew E. Reardon, M.D.
University of Minnesota, 1954
Born: 1927, Died: April 14, 1996

Albert E. Ritt, M.D.
University of Minnesota, 1933
Born: 1908, Died: June 5, 1997

Donald E. Roach, M.D.
University of Minnesota, 1953
Born: 1925, Died: Jan. 26, 1997

John M. Runquist, M.D.
University of Minnesota, 1946
Born: 1920, Died: July 23, 1997

Gene R. Savelkoul, M.D.
University of Minnesota, 1956
Born: 1932, Died: March 23, 1997

Jerome J. Scherek, M.D.
University of Minnesota, 1957
Born: 1932, Died: Jan. 5, 1997

John F. Schmid, M.D.
University of Minnesota, 1942
Born: 1916, Died: July 18, 1997

Paul M. Schollmeier, M.D.
University of Minnesota, 1976
Born: 1950, Died: July 14, 1997

Baxter A. Smith Jr., M.D.
University of Minnesota, 1937
Born: 1914, Died: Dec. 29, 1996

Samuel B. Solhaug Jr., M.D.
University of Minnesota, 1945
Born: 1920, Died: March 13, 1996

Robert K. Sommer, M.D.
Indiana University, 1957
Born: 1932, Died: March 1, 1997

Harold C. Stratte, M.D.
University of Minnesota, 1921
Born: 1894, Died: April 15, 1996

Mien-Fa Tchou, M.D.
Aurora University, China, 1944
Born: 1918, Died: Aug. 3, 1996

Desmond M. Thysell, M.D.
University of Minnesota, 1937
Born: 1912, Died: March 14, 1997

Richard C. Tucker, M.D.
University of Minnesota, 1950
Born: 1922, Died: July 16, 1997

Nejat Turkbas, M.D.
Ankara University, Turkey, 1956
Born: 1933, Died: Feb. 4, 1997

Laurentius O. Underdahl, M.D.
University of Minnesota, 1936
Born: 1907, Died: May 5, 1997

Martin O. Wallace, M.D.
University of Minnesota, 1933
Born: 1907, Died: May 5, 1996

Eric Edwin Wollaeger, M.D.
Harvard Medical School, 1934
Born: 1910, Died: March 22, 1996

Alan R. Zempel, M.D.
University of Nebraska, 1950
Born: 1917, Died: March 21, 1997

People and Places Making Medical News

People

Fairview's Top Executive to Resign

Richard Norling, president and chief executive officer of Fairview Health System, will resign his post next month to become chief operating officer for San Diego-based Premier, a for-profit company that offers services and supplies to a consortium of hospitals nationwide.

Norling, who joined Fairview in 1989, has played a leading role in helping Fairview become one of Minnesota's largest health care organizations. He has directed an expansion that included purchasing or establishing hospitals, primary care clinics, the Ebenezer Society, and other health care enterprises.

Norling said he plans to leave in early October and has agreed to act as a consultant to Fairview once he joins Premier.

AIDS Researcher Named Interim Dean, UMD School of Medicine

Rick Ziegler, Ph.D., professor of medical microbiology and immunology and associate dean for academic and curricular affairs at the University of Minnesota–Duluth, has been named interim dean of UMD's School of Medicine. He replaces **Ron Franks, M.D.**, who left the post September 1 to become vice president for health affairs and dean of the Medical School at East Tennessee State University.

Ziegler's research, supported by the National Institutes of Health, focuses on how components of HIV affect the nervous system.

Minnesota Physician Elected ASCRS Vice President

Sanhat Nivatvongs, M.D., of Rochester, Minnesota, was elected vice president of the American Society of Colon and Rectal Surgeons for 1997-98. Nivatvongs is a professor of surgery at Mayo Medical School and consultant at Mayo Clinic. He has been an ASCRS fellow since 1976 and serves on the society's Self-Assessment Committee.

Fairview Ridges Elects New Chief

The Fairview Ridges Hospital medical staff has elected **Timothy Anderson, M.D.**, new chief of staff, replacing **David Curran, M.D.** Anderson has practiced at Southdale Pediatric Associates in Burnsville for 11 years.

FPA Elects New Board Members and Officers

Fairview Physician Associates has elected the following new members to its board of directors: **William Northrup III, M.D.**, of Cardiac Surgical Associates, P.A.; **Douglas Soderberg, M.D.**, of Paul Larson Ob-Gyn Clinic, P.A.; **Sheila Leatherman**, executive vice president for United HealthCare Corp.; and **David Murphy**, president of international foods, General Mills. It re-elected **Barbara Blumer**, an attorney with Orbavich & Gartner, and **Edward Lindell**, executive vice president, external affairs, for Lutheran Brotherhood.

New officers for the board are Chair **Barry Bershow, M.D.**, of Burnsville Family Physicians, P.A.; Vice Chair **John Anderson, M.D.**, of Orthopedic Surgeons, Ltd.; and Secretary-Treasurer **David Kelby**, retired senior vice president and treasurer of General Mills.

Allina Reorganizes Management Structure

Allina has formed a new management structure intended to organize the $2.4 billion company geographically rather than organizing its HMOs and hospitals separately. Allina was formed in 1994 when HealthSpan, a Twin Cities hospital chain, and Medica, a health maintenance organization, merged. The new structure includes an executive committee to oversee strategy and an operations council to direct the business of health care.

David Strand will chair Allina's metro market planning group, and Steve **Hillestad** will chair the regional market planning group. **K. James Ehlen, M.D.**, Allina president, will chair the executive council, and **Gordon Sprenger**, executive officer, will chair the operations council, with both groups overseeing the metro and regional divisions.

Allina has also appointed **Jeffrey Chell, M.D.**, as system vice president, Clinical Services, and **William MacNally** as system vice president, Information Operations. **John Kleinman, M.D.**, will head up Medical Management and Policy and will also be director for Medica Health Plans.

Summit Medical Chief Resigns

Kevin Green resigned in late July as chief executive officer, president, and board member of the financially troubled Summit Medical Systems, a health care software firm based in Minnetonka. Four months before Green's resignation, the firm had admitted to overstating its financial results for the past three years. **John Nehra**, who controls 13 percent of the company, has taken over as chair and is serving as acting chief executive officer until a new CEO is named.

Places

University Receives Increased Cancer Research Funding

The American Cancer Society has awarded the University of Minnesota Cancer Center an Institutional Research Grant that will provide

$90,000 a year for three years to help fund research projects for junior faculty. This represents an increase of $25,000 a year over previous IRG grants.

"This money gives young researchers the means to test new ideas that may eventually lead to cancer breakthroughs," said **Bruce Blazar, M.D.**, professor of pediatrics and principal investigator. "The University of Minnesota Cancer Center has been actively recruiting new faculty and this additional support can help them get their research projects underway."

Reproductive Health Associates Adds Male Infertility Center

Reproductive Health Associates, P.A., has added a new center for male infertility research and treatment, bringing in internationally recognized expert **Jon Pryor, M.D.** The clinic is the first in the Midwest, and one of the few in the nation, in which a urologist and endocrinologists are in private practice together.

Pryor was formerly with the University of Minnesota Medical School's Department of Urology. Also joining RHA from the university are molecular biologist **Ken Roberts, Ph.D.**, endocrinologist **Bruce Redmon, M.D.**, and nurse **Stacy Glass, R.N.**, who also specialize in male infertility.

HealthEast Clinic Changes Name

HealthEast Clinics–Twin City OB/GYN has changed its name to HealthEast Clinics–Comprehensive OB/GYN Services. The clinic also opened a new site in Maplewood adjacent to HealthEast St. John's Hospital. The clinic has other offices in Maplewood, Shoreview, and Woodbury.

Socioeconomics

Cost of Insuring State Employees Increasing for 1998

Following negotiations with insurance carriers, state officials announced that Minnesota will pay 9.7 percent more to provide insurance to state workers in 1998, possibly signaling significant health insurance increases for all Minnesotans. The state's health insurance plan covers 156,000 state and university employees, retirees, and their dependents. The increase in premiums is the largest for the state employee health program in many years.

BHCAG Stays with HealthPartners as Administrator

The Buyers Health Care Action Group (BHCAG), made up of large employers such as Dayton Hudson Corp. and First Bank, has chosen to stay with HealthPartners for administering the Choice Plus health plan through 1999, but it is asking for bids on the contract for the year 2000. HealthPartners, which has administered the plan since 1993, has almost 300 employees working on the BHCAG contract, handling contracting, claims, billing, support, and data analysis.

BHCAG chose to give a long lead time for competitive bids. "That doesn't reflect any dissatisfaction with HealthPartners," said **Steve Wetzell**, BHCAG executive director, in a *CityBusiness* article. "We clearly believe competition can benefit ourselves and beneficiaries, whether it's among care systems or vendors."

Smoking Ban Takes Effect in Minnesota Prisons

A law mandating that all Minnesota prisons be smoke-free took effect August 1. The law, which passed two legislative sessions ago, prohibits inmates and prison staff from using or carrying any tobacco product while on prison grounds—even the parking lot. The only people who are allowed to use tobacco are American Indian prisoners for religious ceremonies. An estimated 60 percent to 70 percent of Minnesota's 5,200 prisoners smoke, according to **Eric Skon**, assistant commissioner of

ASPEN Medical Group

Full Time Urgent Care

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Occupational Health
Ob/Gyn
Pediatrics

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES

adult facilities at the Department of Corrections.

The law is intended to reduce the state's cost for prisoners' health care coverage; insurance premiums are higher for smokers. Corrections officials say health care costs in the prison system have increased drastically—from $12.6 million in fiscal 1994 to an estimated $18.2 million for the year ended June 30, 1997.

The Perfect Fit...

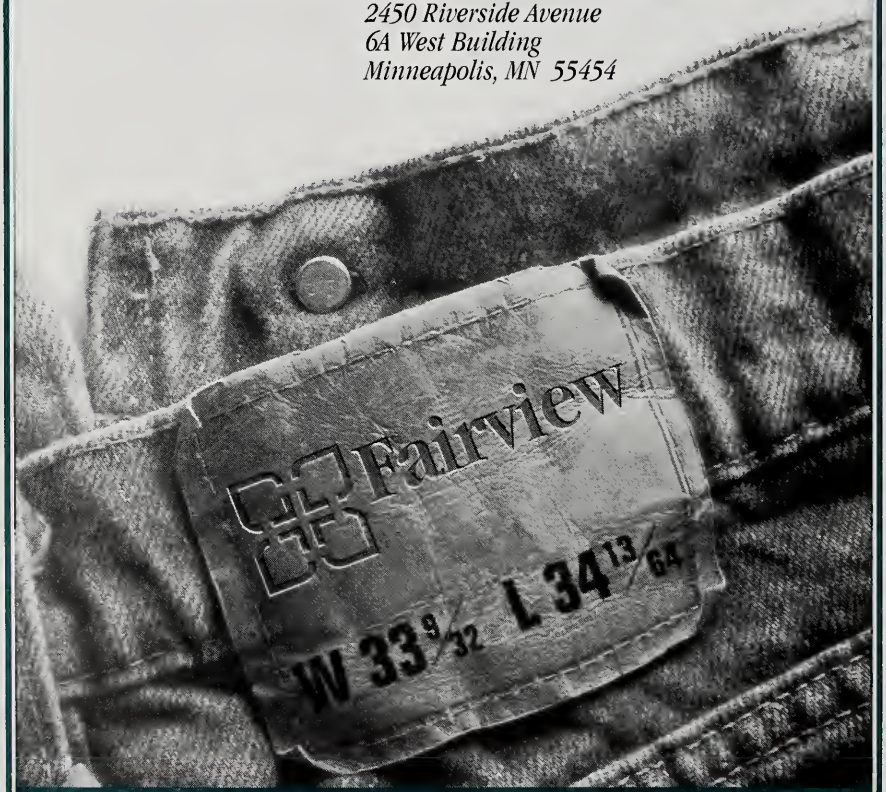
...is a rare find. Fairview Health System represents a wide spectrum of practice and lifestyle options in Minnesota. We will help you locate opportunities that are tailored to fit your needs in communities that match your size.

Opportunities now available in communities large, medium and small (and sizes in between) for...

- **Endocrinology**
- **Family Practice**
- **General Surgery**
- **Internal Medicine**
- **Obstetrics/Gynecology**
- **Orthopedic Surgery**
- **Urgent Care**
- **Urology**

Fairview

Physician Recruitment & Retention Dept.
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454



612-672-2288 or 1-800-842-6469 • E-mail: fhsrecruit@aol.com

HMOs Growing Mostly in Metro Areas

Three-quarters of all HMO enrollment growth in the past three years (about 12 million new enrollees) has occurred in metropolitan markets with more than 1 million population, according to the new report *InterStudy Competitive Edge, Regional Market Analysis.* The report finds that, in larger markets, HMOs tend to have gained more market penetration, to use more capitation, and to be more involved in Medicare and Medicaid. Since 1994, the average large market has moved from 23.3 percent to 31.2 percent HMO penetration.

The report also indicates that larger markets are able to support more HMOs, necessary for greater competition. Baltimore, Charlotte, and Philadelphia are examples of markets with closely matched HMO market shares, higher penetration, and a large number of HMOs. Using an index of competition, market penetration, and number of HMOs as indicators of HMO competitiveness, the least competitive large HMO markets in the country are Minneapolis-St. Paul; Buffalo, New York; Grand Rapids, Michigan; Pittsburgh, Pennsylvania; and Rochester, New York.

HMO competition in some medium markets may be a problem, according to the report. Many moderately sized markets have not seen a new HMO entrant for five years or more. The average small market has not had a new HMO for seven years. Lack of new market entry is associated with lower HMO penetration, less likelihood that HMOs will serve Medicare and Medicaid populations, and often signals that the market is characterized by a single dominant plan.

The report also documents the opposing forces created by provider supply and HMO competition. More provider supply leads to greater use of health care services. More HMO competition leads to less use of health care services.

Mork Clinic Employees Join Union

The 225 employees of Mork Clinic, which has offices in Blaine, Elk River, and Coon Rapids, voted to join the Service Employees International Union Local 113. It is the seventh health care industry addition to the union in the past year, adding about 1,100 new members. Others who have joined the union include employees of St. Therese Nursing Home in New Hope, Nile Health Care in south Minneapolis, and the Mound Medical Clinic. Mork employees voted 135-59 to join the union.

Law & Policy

Judge Throws Out Large ALG Claim Against 'U'

Ruling that the federal False Claims Act does not apply to a state institution, U.S. District Court Judge Richard Kyle has reduced the University of Minnesota's liability in a fraud case over the experimental transplant drug ALG by millions of dollars. His decision throws out one of the government's largest claims, which sought $100 million in damages.

"This is a very good decision for the university and Minnesota taxpayers," said Mark Rotenberg, the university's chief attorney. "The claims that remain are just a fraction of what they were."

However, the university may still have to forfeit millions in illegal profits from the sale of ALG, an unapproved drug manufactured at the university in the 1970s and '80s.

Kyle also threw out the claims of biology professor James Zissler, Ph.D., who had accused the university of trying to fire him for bringing the wrongdoing to light. Under the False Claims Act, he could have been entitled to 15 percent or more of any money the government recovered.

Medical Research

Study Shows Value of Treating High Systolic Blood Pressure

Prescribing a low-dose diuretic for older patients with high systolic blood pressure can reduce their risk of heart failure by 54 percent, according to researchers at the University of Minnesota and elsewhere. Richard Grimm, M.D., Ph.D., University of Minnesota professor of medicine and epidemiology, and colleagues at 16 U.S. medical centers enrolled 4,736 patients over age 60 who had a mean baseline blood pressure of 170/77. About half were treated with low doses of the diuretic chlorthalidone. If that didn't bring the systolic reading down to 159 or lower, the patients were given atenolol or reserpine. The other patients were given a placebo.

About 2 percent of the patients in the treatment group suffered heart failure incidents, compared with about 4 percent in the placebo group. In addition, the stroke rates for patients in the drug treatment group dropped by 36 percent, and the heart attack rate fell by 27 percent. MM

First Call Physicians, Inc.
A Locum Tenens Service
500 Eighth Ave. S.
Buffalo, MN 55313

Clinics/Hospital | Physicians

Locums Coverage = Revenue

- Patients falling through the gaps?
- Physician burnout or illness?
- Shortage of physicians?

- Earn more with less time.
- No administrative headaches.
- Malpractice premium paid.

Experience, Service, Honesty
Call (metro) 682-3852
(toll free) 888-682-3852
(You'll be glad you did!)



The more you give, the more you receive.

Giving U.S. Savings Bonds passes an important lesson on to the future generation. Bonds can teach our children how to save, how interest grows and how a small investment can help make their dreams come true.

Buying U.S. Savings Bonds contributes to a solid and secure America for generations to come. What a great way for you to say, "I believe in your future!"

Buy Bonds at half their face value through your local bank, and share the tradition of U.S. Savings Bonds. They're the gift that gives back more than you've given.

Take Stock in America U.S. SAVINGS BONDS

A public service of this magazine

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

SEPTEMBER 1997

Sept. 5-6 **Orthotics and Prosthetics: A Multidisciplinary Approach to Orthotic and Prosthetic Management** Mayo Foundation; Leighton Auditorium, Siebens Medical Education Building, Rochester, MN. CONTACT: Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 8 **Ettinger Lecture (Neurology)** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 8-11 **Counseling the Compulsive Gambler: Phase II** Minnesota Council on Compulsive Gambling; New Orleans, LA. CONTACT: Elizabeth M. George, 314 West Superior Street, Suite 702, Duluth, MN 55802; 218/722-1503.

Sept. 12-13 **Advanced Trauma Life Support Course** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Sept. 12-14 **Annual Ambulance Medical Directors Retreat** Hennepin County Medical Center; Radisson Arrowwood, Alexandria, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 800/263-4262.

Sept. 19 **Contemporary Issues in Hemodialysis** Hennepin County Medical Center; Sheraton Midway Hotel, St. Paul, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 19 **Second Annual Regional Ob/Gyn Conference** St. Luke's Hospital and Regional Trauma Center; Duluth, MN. CONTACT: Cheryl Jurek, 915 East First Street, Duluth, MN 55805; 218/726-5449.

Sept. 19-20 **Mayo Clinic Update in Hepatology and Liver Transplantation 1997** Mayo Foundation; Minneapolis Hilton and Towers, Minneapolis, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 19-20 **Midwest Glaucoma Symposium** Phillips Eye Institute; Marriott City Center, Minneapolis, MN. CONTACT: Leslie Gibson, Phillips Eye Institute, 2215 Park Avenue, Minneapolis, MN 55404; 612/336-5061; fax 612/870-0315; E-mail gibson@allina.com

Sept. 19-20 **Through the Eyes of Others: Envisioning Culturally Competent Healthcare** Hennepin County Medical Center; Earle Brown Heritage Center, Brooklyn Center, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 21-23 **Echocardiography for the Sonographer 1997: Focus on Valvular and Myocardial Disease** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 21-25 **Advances in Diagnostic Radiology** Mayo Foundation; The Empress Hotel, Victoria, British Columbia. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 24-26 **Advanced Radiology Life Support Course** Mayo Foundation; The Empress Hotel, Victoria, British Columbia. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Sept. 25-26 **24th Mayo Clinic Pediatric Days** Mayo Foundation; Leighton Auditorium, Mayo Clinic, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Sept. 26-27 **Statistical Computing** Hennepin County Medical Center; Brainerd, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Sept. 26-28 **The 1997 Interim Meeting of the Society for Pediatric Pathology** Society for Pediatric Pathology; Hyatt Regency Hotel, Minneapolis, MN. CONTACT: Cathy Vaidich, 2525 Chicago Avenue South, Minneapolis, MN 55404; 612/813-6711.

OCTOBER 1997

Oct. 2-3 **Annual Forensic Science Seminar** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 2-3 **Meeting the Challenges of Rural Cancer Care** St. Mary's/Duluth Clinic Health System; Duluth, MN. CONTACT: Mary Connolly, Educational Services, St. Mary's/Duluth Clinic, 400 East Third Street, Duluth, MN 55805; 218/726-4434 or fax 218/726-4273.

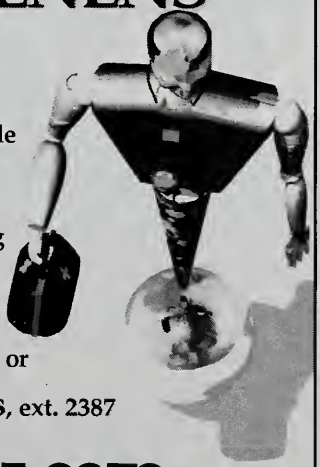
Oct. 2-3 **1997 Oncology/Lake Superior Rural Cancer Care Project Conference** St. Mary's/Duluth Clinic Health System; Duluth Entertainment Convention Center, Duluth, MN. CONTACT: Diane Torvick, 400 East Third Street, Maildrop 5AV2ME, Duluth, MN 55805.

Oct. 2-3 **Research Statistics** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 5-8 **The 13th Annual Echocardiography in Congenital Heart Disease Symposium** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 9-10 **Annual Orthopedic and Trauma Seminar** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 9-10 **Clinical Research Methods** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Staff Care, Inc.
"The nation's fastest growing locum tenens firm"
YOUR BEST MOVE FOR LOCUM TENENS
• Nationwide opportunities
• Government settings available
• Occurrence malpractice
• Paid travel, licensure, lodging

Ask for :
John Moberly, ext. 2381 or
Melanie McReynolds, ext. 2387
(800) 685-2272
http://www.locumsnet.com
Staff Care is proud to sponsor the Country Doctor of the Year Award
Unable to place J-1 or H-1 physicians

Minnesota Medicine
AN EXCELLENT ADVERTISING INVESTMENT

Target marketing pays real dividends with your space advertising in *Minnesota Medicine*, the official journal of the Minnesota Medical Association.

Delivered directly to offices, hospitals, and clinics, *Minnesota Medicine* reaches your key clients and prospects in their business setting.

For complete advertising information contact:

Sherry Makela
Minnesota Medicine
3433 Broadway Street NE, Suite 300
Minneapolis, Minnesota 55413
612/623-2880
800/DIAL-MMA

Compare your personal insurance coverages to Atlantic Mutual's

(and then call MMBR Insurance Agency at 800-298-6627).

This plan is administered for the members of the Minnesota Medical Association by:

The Christensen Group

University of Maryland Baltimore

Them.* Us.

Medical Professional Endorsement	NO	YES
Loss of Wages	$50/Day	$500/Day
On-Residence Business Property Coverage	$2,500	$25,000
Off-Residence Business Property Coverage	$250	$10,000
Electronic Apparatus Coverage	$1,000	$2,500
Computer Records Coverage	NO	$5,000
Umbrella Coverage Available up to $10 Million	NO	YES
Non-Profit Directors and Officers Coverage	NO	YES
Scheduled Property Covered as Valued	NO	YES
Total Loss Cash Settlement Option	NO	YES
Water Back-Up Coverage	NO	YES
Mortgage Renegotiation Coverage	NO	YES
Lock Replacement Coverage	NO	YES
Worldwide Fine Art Coverage	NO	YES

*Based on ISO standards

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED

MMBR

MINNESOTA MEDICAL
BUSINESS RESOURCES
OWNED BY
MMA & HMS

Bottom line, you pay insurance premiums to get the best coverage. One way to make sure you're getting the best coverage is to buy a personal insurance policy that's designed for you.

Atlantic Mutual Insurance Company's Atlantic Master Plan, combined with our Medical Professional Endorsement, covers almost all of your precious possessions in one policy. You get coverage for up to three homes, seven cars, jewelry, furs, fine art and boats. And, you get extra time to tell us about newly acquired vehicles, boats and other valuables.

Compare your personal insurance policy to Atlantic Mutual's. Then contact MMBR Insurance Agency, Inc., 3433 Broadway St. NE, Suite 375, Minneapolis, MN 55413. Phone 800-298-6627 today.

AtlanticMutual Companies

Excellence in property and casualty insurance since 1842.

This advertisement contains only a general description of coverages and does not include all the benefits and limitations found in the policy. The insurance policy and not this descriptive advertisement will form the contract between the insured and the insurance company.

Oct. 10 **Sixth Annual Conference for CME Planners** Minnesota Medical Association; Northland Inn, Brooklyn Park, MN. CONTACT: Jane Phillip, MMA, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/342-5662.

Oct. 15 **Domestic Violence Conference** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 16 **Medical Staff Meetings** Hennepin County Medical Center; Whitney Hotel, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 16-19 **American Society of Addiction Medicine's 10th National Conference on Nicotine Dependence** American Society of Addiction Medicine; Minneapolis Marriott City Center, Minneapolis, MN. CONTACT: Sandy Metcalfe, 4601 North Park Avenue, Chevy Chase, MD 20815; 301/656-3920.

Oct. 24-25 **Psychiatry in Practice: Honoring Tradition, Incorporating Innovation** Mayo Foundation; Siebens Building, Mayo Clinic Campus, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 27-29 **Clinical Reviews 1997** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 30 **Geriatric Update for the Primary Care Physician** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

NOVEMBER 1997

Nov. 10-12 **Clinical Reviews 1997** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 13-15 **Mayo Clinic Ob/Gyn Clinical Reviews** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Healthful Eating

American Heart Association℠
Fighting Heart Disease and Stroke

Fruits and vegetables are important components of a healthful diet. Here's why:

- **They are easy to fix and serve**
- **There are so many choices**
- **They are the original "fast food"**
- **They taste great**
- **They are good for your health**



©1996, American Heart Association

MMA Annual Meeting

Schedule of Events

Sunday, Sept. 14

12:00 NOON to 6:00 P.M.
General Registration

12:00 NOON to 2:00 P.M.
MEDPAC Annual Meeting

2:00 P.M. to 4:00 P.M.
Board of Trustees Meeting

2:00 P.M. to 3:00 P.M.
Young Physician Section

3:00 P.M. to 4:00 P.M.
Resident Physician Section

4:00 P.M. to 6:00 P.M.
1997 Issues Forum

6:00 P.M. to 8:30 P.M.
Welcome Reception, Outdoor Barbecue

8:00 P.M. to 9:00 P.M.
Women Physician Reception

MMA Annual Meeting
September 14-16, 1997
Madden's Resort
Brainerd, Minnesota

Monday, Sept. 15

6:00 A.M. to 7:30 A.M.
Breakfast

6:45 A.M. to 5:00 P.M.
General Registration

7:00 A.M. to 8:00 A.M.
Medical Student Section

7:00 A.M. to 8:45 A.M.
Component Society Caucuses:
•Ramsey •Hennepin
•Greater Minnesota

9:00 A.M. to 10:30 A.M.
House of Delegates (Session I)

10:30 A.M. to 11:15 A.M.
AMA Open Forum

11:15 A.M. to 12:45 P.M.
Awards Lunch

1:00 P.M. to 3:30 P.M.
Reference Committee Open Hearings

3:30 P.M.
Shot Gun Golf Tournament

3:30 P.M. to Until Completion
Reference Committee Exec. Session

4:30 P.M. to 6:00 P.M.
Organized Medical Staff Section

5:00 P.M. to 6:00 P.M.
AMA Delegation Meeting

6:30 P.M. to 7:00 P.M.
Pre-Inaugural Reception

7:00 P.M. to 9:00 P.M.
President's Inaugural Dinner

9:00 P.M.
Afterglow Reception

Tuesday, Sept. 16

7:00 A.M. to 8:30 A.M.
Breakfast

7:00 A.M. to 8:00 A.M.
Board of Trustees Breakfast Meeting

8:30 A.M. to 12:00 NOON
General Registration

8:30 A.M. to 10:15 A.M.
Component Society Caucuses:
•Ramsey & Hennepin
•Greater Minnesota

10:30 A.M. to 3:00 P.M.
House of Delegates (Session II)

12:00 NOON
Spouse Luncheon

3:00 P.M.
Board of Trustees
Organizational Meeting

Suppose a ship was sinking, and you could only fit 7 Of us into the last lifeboat.



which 3 would you leave behind?

That's the problem we're facing with childhood leukemia. Thanks to research, 7 out of 10 kids with leukemia will survive. But 3 won't. That's unacceptable. To their families. To us. And to you. Help us reach our goal. Support the Leukemia Society of America's Cure 2000 campaign. If you or someone in your family needs help, call the Leukemia Society's toll-free resource line at 1-800-955-4LSA.

leukemia®
society of america

Fighting:
leukemia
lymphoma
multiple myeloma
Hodgkin's disease

This advertisement was prepared for the benefit of the Leukemia Society of America by Robinson, Yesawich & Pepperdine, Inc., Orlando, Florida, 1995.

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., September 15 for November ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

Olmsted Medical Center is seeking BC/BE physicians in family medicine. Great opportunity for well-trained physicians to join a 75-physician multispecialty group in a dynamic, progressive practice. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes 10 branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (*5/96-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Part-time Neurologist wanted for multidisciplinary office. No call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Urgent Care Physicians: We are a growing urgent care practice looking for BC/BE physicians to work full or part time to staff our four clinics. We currently have three locations in the metro area and one location in Mankato and are planning on expanding in 1997. Please contact Cara Auge at 612/593-9818 or 800/511-2820 for more information on joining our growing practice, or send inquiries to 9800 Shelard Parkway, #210, Plymouth, MN 55441. (4/97-R)

Office Space for Rent: Medical/dental only, Burnsville, 35W/35E interchange. Modern, 2,000 square feet. Garage parking. Call Dick, 612/435-4144. (8/97-R)

Ob/gyn BC/BE to join progressive 33-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographic referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AOA/EOE. *3-11/97

Mankato, Minnesota: Full-time psychiatrist. Excellent opportunity for BC/BE psychiatrist to join our multidisciplinary team. Competitive salary and benefit package. Mankato is a high-quality town 70 miles south of Minneapolis. Excellent schools and recreational activities. For more information, contact Ed Sathoff, M.D., or Patricia Blumenreich, M.D., at 507/387-3195, or send/fax CV to Psychiatric Clinic, 410 Jackson Street, Suite 200, Mankato, MN 56001; Fax: 507/625-2224. 3-11/97

Family Practice—rural but near: Independently owned primary care group located 45 minutes from Minneapolis seeks family practice physician. Growing community offers professional options for significant other, walking and biking trails, good school choices, strong economic base, and safe environment. Practice offers four-day clinic week, 1:6 call, supportive colleagues, new facilities, and dedicated staff. Call Verne Meyer, 800/967-2711, or fax CV to 320/587-7252, E-mail: delacore@hutchtel.net. 3-11/97

Allina knows what's important to our physicians. That's why we've created a progressive, not for profit health organization that values your time and talent.

"...what Allina did for our careers was great; what they did for our families was amazing."

We offer desirable call schedules and excellent physician support, allowing you to do the work you love, without abandoning your loved ones. Allina is currently seeking physicians in the following categories: Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, Locum Tenens, and Dermatology.

Our Minnesota/Wisconsin locations have numerous metro and rural opportunities —along with our rewarding career structure, excellent compensation package, and family relocation assistance.

If you love your work, you'll love Allina.

Call our Physicians Services Group
612-992-3093 or 1-800-248-4921
Fax 1-612-992-3669
Allina Health System . Route 80775
5601 Smetana Drive . Minnetonka, MN 55343

ALLINA
HEALTH SYSTEM

Minnesota: BC/BE general orthopedist or medical orthopedist needed to complement a well-established solo orthopedic practice. Competitive salary guarantee and benefits. Excellent schools, recreation, and outdoor activities. Subspecialty training welcome. Please fax resume to Lori at 507/238-1997. 3-11/97

Family Practice—Chetek: Luther Midelfort–Mayo Health System, a thriving 160-physician multispecialty clinic and hospital in Eau Claire, Wisconsin, is seeking a BC/BE family practitioner for our Chetek, Wisconsin, office. A desire to practice ob is essential. General call of 1:10 and ob call of 1:7 is expected. Physicians do not have first call in the emergency department. Will share a newly remodeled office with one other family practitioner. Chetek, located 40 miles north of Eau Claire, is in the heart of resort country. Located on a chain of six connecting lakes, Chetek offers four-season recreation for the outdoor enthusiast. For further information, contact Christie Blink, Physician Recruitment Coordinator, at 800/573-2580, or fax 715/838-6688. 3-11/97

SUPPLEMENT YOUR INCOME
Medical/Legal Firm seeks Specialists
in **Neurology, Neurosurgery**
Cardiology and **Oncology**
to Perform
Independent Medical Exams
and **Record Reviews** in
*Minnesota *South Dakota
*North Dakota *Wisconsin
Must be
Board Certified
In Private Clinical Practice

EvaluMed
Southdale Medical Building
Suite 571
6545 France Avenue South
Minneapolis, MN 55435
(612) 925-5882 (800) 806-5666
Contact: Stephanie Rozman, C.O.O.

FAMILY PRACTITIONERS: ARE YOU LOOKING FOR...

A CHALLENGING CLINICAL PRACTICE?
- Join 3 F.P. and 2 N.P. in a clinic with 25,000 annual patient visits
- Financially stable 31-bed hospital, 74-bed LTC, and HH agency
- Access to 26 outreach specialists
- Including Operative, Obstetric and Emergency Services

A GOOD LIFE?
- Working flexible 4.5 day week with 1:4 weekend and night call
- A progressively diverse rural community
- Within two hours of Fargo and Sioux Falls and three hours of Twin Cities
- Recreation: Big Stone Lake, 18-hole golf course, National Wildlife Refuge

A SUPPORTIVE COMMUNITY?
- Community-based Health Care Foundation with $1 million dollars pledged
- Providing competitive package including:
  - Guaranteed starting salary w/incentive
  - Two year housing allowance
  - Educational loan repayments

C.V. in confidence to Administrator
Ortonville Area Health Services,
Ortonville, MN 56278
Phone: (320)839-2502; FAX: (320)839-2507. EOE.

FAMILY PRACTICE MEDICAL CENTER
OF WILLMAR, P.A.

Family Practice Opportunity: Seven-family physician group seeks additional full-time family physician. Family Practice Medical Center of Willmar, Minnesota, P.A., is a physician-owned clinic located in the regional health care center for west-central Minnesota. Broad secondary specialist services provided in community, 24-hour ER physician coverage, and after-hour nurse triage service. Teaching opportunities as clinical faculty for University of Minnesota. Guaranteed salary first year, with a full range of benefits and the opportunity for ownership. Outstanding quality of life including four-season recreational opportunities, strong community economy, excellent educational system, and a regional retail center. Inquiries to Gary McDowell, Administrator, at 320-235-7232, or fax 320-231-8602.

Neurologist, Oncologist, Urgent Care, ENT, Dermatologist

There are immediate openings at Brainerd Medical Center for the following specialties: Neurology, Oncology, Urgent Care, Ear, Nose and Throat, and Dermatology.

Brainerd Medical Center, P.A.
- 36-physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota
- Surrounded by the premier lakes of Minnesota
- Located in central Minnesota less than 2 ½ hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:
- Curt Nielson
  (218) 828-7105
  or (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

HealthPartners®
St. Paul-Ramsey Medical Center

CME
640 Jackson Street
St. Paul, MN 55101
(612) 221-3992

CONTINUING MEDICAL EDUCATION
1997 FALL/WINTER CONFERENCE SCHEDULE

NIOSH-Approved Spirometry Training	October 6-7
Strategies in Primary Care	November 13-15
Changing General Surgical Practices	November 13-14
Current Challenges to Employee Health: The Health Care Environment, Infection Control Issues, Ergonomics, Workplace Violence	November 20-21
Cardiovascular Conference	December 4-5
Pediatric Orthopaedic Update	December 5
Fitting the Work to the Worker: Preplacement Evaluation, Advanced Medical Case Management	December 11-12

INFORMATION AND REGISTRATION:
Continuing Medical Education, St. Paul-Ramsey Medical Center
640 Jackson Street, St. Paul, MN 55101
Phone 612-221-3992 • Fax 612-292-4773
St. Paul-Ramsey Medical Center/Ramsey Clinic/Ramsey Foundation are Members of the HealthPartners Family of Health Care Organizations



ALEXANDRIA CLINIC, P. A.

The Alexandria Clinic, P.A., is a 32-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- PEDIATRICS
- INTERNAL MEDICINE

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

Urgent Care

Physicians

Urgent care openings at five Procare sites throughout the Twin Cities. BE/BC Family Practitioners and Internists, comfortable with pediatrics, to work evenings, weekend, and holidays. Permanent part-time (32-40 hours every two weeks) with benefits. Moonlighting needed and will consider residents.

MERCY & UNITY HOSPITALS

ALLINA HEALTH SYSTEM
Debbie Modder

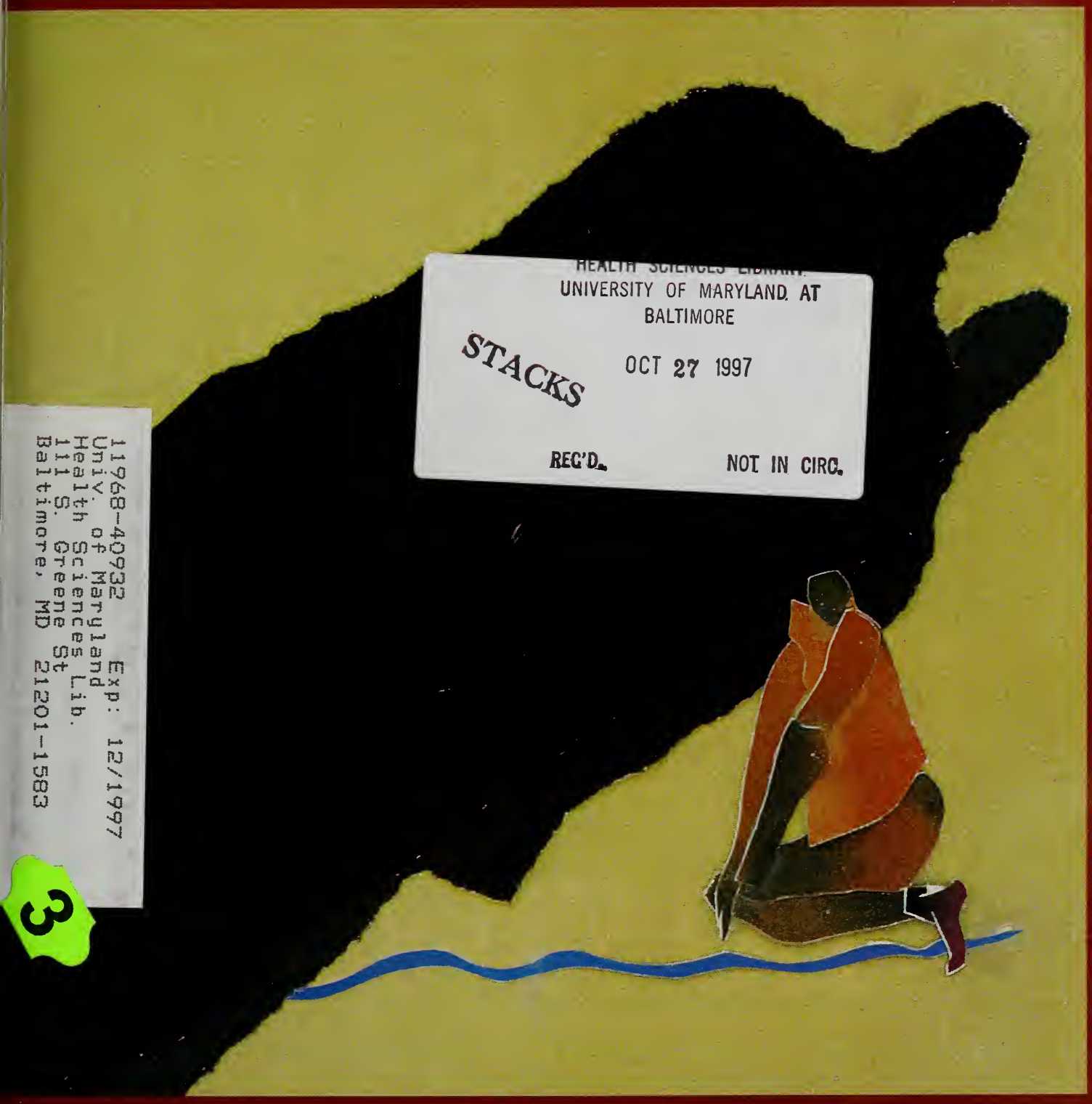
For more Information:
Allina Health System
5601 Smetana Drive Route 80775
612-992-3094 / 800-284-4921
Fax: 612-992-3669

SEPTEMBER 1997 INDEX TO ADVERTISERS

Affiliated Community Medical Centers 44
Alexandria Clinic, P.A. 64
Allina Health System 22, 23, 62, 64
Aspen Medical Group 51
Austin Medical Center 9
Bone, Muscle & Joint, Inc. 16
Brainerd Medical Center 63
Central Minnesota Group Health Plan 44
Chisago Health Services 16
EvaluMed 62
Fairview Clinic Services 52
Family Practice Medical Center 63
First Call Physicians, Inc. 53
Gillette Children's Specialty Healthcare 44
HealthEast Capitol Medical Laboratory 32
HealthEast Bethesda ..... Cover 4
HealthSystem Minnesota 23
Hennepin County Medical Center 17
Kurilla Real Estate Ltd. 9, 29
Medical Protective Company ..... Cover 2
Midwest Medical Insurance Co. 3
MMBR 41, 42, 47, 56, 57
Multicare Associates of the Twin Cities 51
Norwest Center 31
Ortonville Area Health Services 62
PMIC, Inc. 46
Spectrum Emergency Care 26
St. Mary's/Duluth Clinic Health System 29
St. Paul-Ramsey CME 63
Staff Care, Inc. 55
Star Tribune 9
THC Minneapolis 5
University of Minnesota 23
Walker Art Center 8
Whitesell Medical Locums, Ltd. 22

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS



HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE
STACKS
OCT 27 1997
REG'D.
NOT IN CIRC.

11968-40932 Exp: 12/1997
Univ. of Maryland
Health Sciences Lib.
111 S. Greene St
Baltimore, MD 21201-1583

3

DOMESTIC VIOLENCE

Treating the ABUSED and the ABUSER

OCTOBER 1997



THE
MEDICAL PROTECTIVE COMPANY®

Professional Protection Exclusively since 1899

To reach your local office, call 800-344-1899.

GOLD CORPORATE AFFILIATE
MGMA
FOUNDED 1926
PROGRAM UNDERWRITER

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Alex Hackworth.

DEPARTMENTS

2 ..... Editor's Notebook

21 .... Domestic Violence Resource Guide

42 .... Author Instructions

53 .... News Clips

63 .... CME in Minnesota

65 .... Classified Ads

68 .... Index to Advertisers

FACE TO FACE

6 **A Promising Partnership** ..... Carolyn Griffith
Family physician Michael Cline and battered women's advocate Rebecca McLane team up to assist victims of domestic violence.

EDITORIAL

10 **When Symptoms Defy Diagnosis** ..... David McCollum, M.D.
Ask your most difficult and complex patients about personal violence and abuse; you may be surprised.

FEATURE STORY

14 **Help for Men Who Hurt: Treating the Batterer** ..... Kim Palmer
Are men who batter trying to dominate women, or are they suffering from childhood wounds? Programs differ on what makes abusers tick and what makes them well.

PERSPECTIVES

24 **Kids at Risk** ..... Ericka Sojourner Davis
For young adults and children, violence—in the family, at school, on dates—is a serious health and social problem.

CLINICAL & HEALTH AFFAIRS

26 **Domestic Violence: Reality for Some of Your Toughest Patients** ..... Therese Zink, M.D.

43 **Screening for Domestic Violence in a Rural Family Practice** ..... Deane Johnson, M.D., and Barbara Elliott, Ph.D.

MEDICINE LAW & POLICY

47 **Legal Issues and Remedies for Victims of Domestic Violence** ..... Loretta M. Frederick, J.D., and Andrea C. Farney, J.D.
Although physicians may be tempted to report domestic abuse to authorities, in most cases, they can better serve patients by providing compassion, basic legal information, and referral.

33 The Monitor

Highlights ..... *1997 MMA Annual Meeting • Action on resolutions • Election of officers*

An Epidemic Sanctioned by Society

One of these days, Alice!" Ralph Kramden used to bellow in the 1960s TV show "The Honeymooners." Jackie Gleason, as the blustering bus driver Ralph Kramden, rarely delivered a line in less than a bleacher yell. Although Ralph never physically abused his wife, Alice, the verbal abuse was thick. In those pre-OJ days, the Kramdens' marital clashes fueled jests and jousts that kept the series popular for years. But Ralph wouldn't get many laughs today. Violence in the home, with its invariable prelude, verbal abuse, and its occasional postlude—homicide—is too prevalent and too painful for jokes. And domestic abuse is not just an issue for sociologists and criminologists; it's a medical problem.



"Treating the medical problem without confronting the social problem is like treating TB by giving Tylenol for the fever."

This month's *Minnesota Medicine* covers the etiology, diagnosis, and treatment of domestic abuse. Our feature article on treating abusers delves into theories of the roots of abuse. Therese Zink's and David McCollum's articles discuss detecting abuse in the clinic and emergency department. Details about help for the abused and the abuser are found in several stories, including the Face to Face, Feature Story, and Perspectives.

Domestic violence hits the personal, the professional, and the political. For the individual, violence at home corrupts what should be a haven of love, trust, and security into a hell of dysfunction, dread, and possibly death. The relationships that should anchor the soul instead threaten the body. Domestic tranquility becomes daily terror.

For medicine, the diagnosis and treatment of domestic abuse are tricky. Simple bruises, chronic pain, or ER recidivism may be signs of an inflammatory home life. Treating the medical problem without confronting the social problem is like treating TB by giving Tylenol for the fever. If physicians do uncover abuse, the knee-jerk inclination to tell the victim to "just leave the guy" is not helpful and won't lead to effective treatment.

For society, domestic violence is an epidemic—and reported abuse is just the tip of the iceberg. Looming even larger than incidence statistics is the potentially lethal codependency of a society that has yet to confront its attitudes toward male roles, prostitution, pornography, and media violence, which aid and abet domestic violence. Only when we understand our complicity in the societal sanction of male control and exploitation of women will we address the core etiology of domestic abuse.

The encouraging news is that treatment is available. There are options for the abused and the abuser. Society, too, is gradually getting treatment. What was previously accepted is now frowned upon; what was previously unsaid is talked about.

Alice took a lot from Ralph. But her acerbic sarcasm won her most of the laughs and all of the moral victories. The victory against domestic abuse that will make homes safe will come when medical practitioners learn to identify and help the abused and when our society confronts its violent soul.

–Charles R. Meyer, M.D., Editor-in-Chief

University of Maryland Baltimore

A new name for our next century of care and service.



We've accomplished a lot in our first century. We've earned an international reputation as one of the top-ranked hospitals in burn, trauma and emergency services — a history of excellence that extends to cardiology, pediatrics and surgery. We continue to serve more communities and our physicians are part of the region's largest multi-specialty medical group. Over the past five years, we have invested more than $70 million in improvements to our hospital — from state-of-the-art facilities and equipment to more private rooms, additional parking and renovated decor. As we approach the next century, we continue to build on our expertise and commitment to excellence to become the hospital of choice in our region.

A new century, a new name: Regions Hospital.

St. Paul-Ramsey Medical Center has changed its name to Regions Hospital.

Regions Hospital℠

'97 HealthPartners, Inc., Minneapolis, MN.

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editors
Lee J. Engfer
Susan Rodsjo

Assistant Editor
Juliet Ramotar

Graphic Designers
Mike May
Susan Rodsjo

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine*. The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/DIAL MMA (342-5662).

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine*. Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1997-98 Officers

President
Kent S. Wilson, M.D.

President-Elect
Judith F. Shank, M.D.

Chair, Board of Trustees
Paul C. Matson, M.D.

Vice President
Anthony C. Jaspers, M.D.

Secretary
Robert G. Milligan, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Blanton Bessinger, M.D.

Vice Speaker of the House
Gary D. Hanovich, M.D.

Past President
Raymond G. Christensen, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Kendra Flanagan

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Keith D. Larson, M.D.

West Metro
Timothy J. Crimmins, M.D.
Gary D. Hanovich, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth Crabb, M.D.
Lyle Munneke, M.D.
Bruce A. Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/DIAL MMA (342-5662)

Fax: 612/378-3875

E-mail: mma@mnmed.org

Web site: www.mnmed.org

Baltimore








THIS PUBLICATION AVAILABLE FROM UMI

This publication is available from UMI in one or more of the following formats:

- **In Microform**--from our collection of over 18,000 periodicals and 7,000 newspapers
- **In Paper**--by the article or full issues through UMI Article Clearinghouse
- **Electronically, on CD-ROM, online, and/or magnetic tape**--a broad range of ProQuest databases available, including abstract-and-index, ASCII full-text, and innovative full-image format

Call toll-free 800-521-0600, ext. 2888, for more information, or fill out the coupon below:

Name _____

Title _____

Company/Institution _____

Address _____

City/State/Zip _____

Phone ( ) _____

I'm interested in the following title(s): _____

_____

UMI
A Bell & Howell Company
Box 78
300 North Zeeb Road
Ann Arbor, MI 48106
800-521-0600 toll-free
313-761-1203 fax

UMI

The Right Care . . . The Right Setting . . . The Right Time



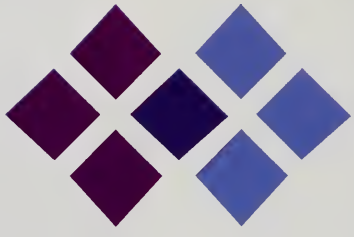
As an extended, critical care hospital focusing on the acutely ill, medically complex patient, THC · Minneapolis aggressively transitions patients to the most appropriate level of care, whether that be a skilled nursing home, subacute facility or home health care. Such was the case with Mr. Ayott, 47 years old, who suffered severe injuries to his chest and lungs in a disastrous car accident. After being stabilized at an acute care hospital, Mr. Ayott transferred to THC to undergo ventilator weaning, wound care, and physical and occupational therapy. With a successful weaning rate of 78% and a new inpatient pulmonary program, THC made it possible for Mr. Ayott to receive the right care in the right setting at the right time.

THC
Minneapolis
A Subsidiary of Transitional Hospitals Corporation

612-588-2750

Medically Complex Program · Pulmonary/Ventilator Program
Wound Care Program · Low Tolerance Rehabilitation Services

A Promising PARTNERSHIP



Family physician Michael Cline and battered women's advocate Rebecca McLane have teamed up to assist victims of domestic violence.



By Carolyn Griffith

To end a violent relationship, a battered woman needs a place where she feels safe to tell the truth about her injuries; she needs a confidant who will listen to, respect, and help her, without coercion or judgment.

"To simply acknowledge and care is an act of intervention," explains J. Michael Cline, M.D., a family physician with HealthPartners St. Paul Clinic. "It shines a light on the situation and opens the door to the next step."

If a doctor asks questions the wrong way, however, it's not going to help, points out battered women's advocate Rebecca McLane.

Cline and McLane collaborated on a project to make clinic exam rooms a haven for victims of domestic abuse. The project is a joint initiative of the St. Paul Domestic Abuse Intervention Project (where McLane works) and Ramsey Family Physicians (where Cline did his residency). In September, the Minnesota Medical Association recognized their efforts with a Stop the Violence Award, which Cline and McLane received at the association's Annual Meeting in Brainerd.

Cline and McLane approach the issue of domestic abuse from different angles. Cline, long committed to social activism, sees violence in the home as a social and health problem that he and other family physicians can help eliminate. McLane, who's been interested in issues of women's equality and social justice since she was in high school, first began working with battered women shortly after she graduated from Macalester College in 1982. She considers the medical care system a place where victims of family violence can reach out for help and support. Part of the cycle of control and violence, McLane explains, is that the batterer often restricts the victim's movement and activity outside the home; sometimes the only place she's allowed to go is to the doctor.

Creating an atmosphere in which a battered woman feels safe enough to talk about how she got her black eye or broken arm is more complicated than one might imagine. Many aspects of the hierarchical, results-oriented medical system echo the emotional tyranny that made her feel powerless in the first place. "We have to



PHOTOGRAPH BY JOHN NOLTNER

teach doctors to do the opposite of what they're trained to do, which is behave authoritatively," says McLane, hospital/clinic program coordinator for the St. Paul Domestic Abuse Intervention Project (SPIP).

CREATING THE PARTNERSHIP

As a medical student at the University of Michigan in Ann Arbor, Cline was involved with Physicians for Social Responsibility, which used a preventive medical model to protest nuclear war . He expected that during his residency he probably wouldn't have time for activism. "Residency is a submersion experience," he says.

But his pessimism was unwarranted. "I lucked into a wonderful residency program that placed a high value on remaining human," Cline explains. When he began his residency in 1990 with the Department of Family and Community Medicine at St. Paul-Ramsey Medical Center (now Regions Hospital), residents and faculty members had a strong rapport and often got together socially. One topic that continually came up was how uncomfortable and poorly prepared the residents felt about identifying and treating victims of domestic violence.

After months of informal discussion and research, the family medicine residents and staff decided to build working relationships with domestic abuse intervention organizations. In 1991, Cline and others developed a CME conference on the topic and invited local battered women's shelters and other groups. SPIP's director, Shelley Johnson, wrote back asking why her local organization hadn't been included in planning the event.

"The answer was that, at the time, we were incredibly ignorant," says Cline, who was assigned to smooth the waters. (Apparently he was successful; he and Johnson are now married and the parents of an infant daughter.)

With SPIP represented at the conference, discussions about a more formal partnership began to ferment. Cline spearheaded the medical side and McLane, then a legal advocate for SPIP, provided the battered women's movement perspective. "We did a lot of talking and brainstorming," McLane recalls. "It was really exciting, all that enthusiasm and energy."

The resulting family violence project adopted several goals:

- Identify people who are experiencing domestic violence;
- Collaborate with clinic patients and SPIP to deal with and prevent domestic violence;
- Make Ramsey Family Physicians (affiliated with Regions Hospital) a safe and welcoming place for domestic abuse victims referred for medical care by SPIP;
- Share experience and knowledge with other medical providers, learning from others when possible.

TRAINING HEALTH CARE PROVIDERS

Cline and McLane, along with colleagues from the residency program, SPIP, and the public health department, have developed tools to accomplish their

MMA'S STOP THE VIOLENCE AWARDS

The Minnesota Medical Association annually honors individuals and groups for efforts to end domestic violence. At the MMA's Annual Meeting September 15, the association presented Stop the Violence Awards to J. Michael Cline, M.D., and Rebecca McLane (both profiled here), Linda Ledray, R.N., Ph.D., and the Maple River Community Network.

LINDA LEDRAY

Linda Ledray developed the Sexual Assault Resource Service (SARS) for Hennepin County Medical Center. The program, now used at seven hospitals in Hennepin County and being expanded statewide, is fast becoming a model for similar programs around the country. SARS employs specially trained nurses to perform evidentiary exams and collect evidence from survivors of sexual assault and maintains the evidence for law enforcement purposes.

As a researcher and director of SARS and as a nurse working directly with survivors in emergency departments, Ledray has helped build much-needed bridges between survivors, medical providers, and law enforcement personnel. The results are improved services for survivors and better chances of capturing and prosecuting violent offenders. See this month's *Monitor* for information on a new Mankato program modeled after SARS.

MAPLE RIVER COMMUNITY NETWORK

The MMA gave the Stop the Violence Award to the Maple River Community Network for its grassroots efforts to promote a strong anti-violence message in four rural Minnesota communities—Amboy, Good Thunder, Mapleton, and Minnesota Lake.

After a survey of the communities' youths revealed bullying and other violent behavior, drinking, and drug use, residents and town officials responded by creating the network as a means to build community support for their children. The network has sponsored an anti-violence awareness campaign, held neighborhood block parties, sponsored parent-education classes and workshops, and involved senior citizens in prevention activities.

Watch for the December issue of *Minnesota Medicine* for more about the survey that inspired the network, *Search Institute Profiles of Student Life: Attitudes and Behaviors,* and how communities can promote healthy behaviors among adolescents.

goals, including a family violence screening protocol, a domestic abuse curriculum for Regions Hospital's family medicine residents, and posters and brochures for exam rooms. These tools are used extensively in Minnesota and have been ordered by health care organizations throughout the United States and Canada.

The challenge in developing a curriculum, Cline says, is to help medical residents understand the complexities of family violence and the value of raising issues of control and violence respectfully—even if doing so leaves providers feeling like they're "not doing anything" to change the situation. With proper training, he notes, providers can avoid common pitfalls, such as telling the victim to leave the relationship or calling the police without the victim's consent.

"Battered women are really good at surviving. They know when it's safe to go home and when it isn't," explains McLane, who notes that some doctors feel that reporting domestic abuse to the police should be mandatory. "I think that's a terrible idea because it destroys trust and takes away the patient's autonomy."

During the second year of family medicine residency at Regions Hospital, doctors spend a half day in court with domestic violence victims and advocates. "This is real-time experience, delving into a battered woman's reality," Cline says. "Health care providers need to see that leaving a violent relationship is not as easy as stepping out the door. And unlike many other problems that people bring to the exam room, it is not our job to fix the situation, but to offer information, resources, and support, so the victim can navigate her own pathway."

Since its first CME conference, Cline helped organize two more CME courses on domestic violence, and McLane and Cline have made presentations at meetings and events for the University of Minnesota Medical School, the National Coalition Against Domestic Violence, the Society of Teachers of Family Medicine, local public health nurses, and many clinics.

After Ramsey Family Physicians became part of HealthPartners in 1993, McLane and Cline helped create HealthPartners' Institute for Clinical Systems Integration guidelines for domestic abuse screening and treatment. Since completing his residency and community medicine fellowship at Ramsey Family Physicians in March 1996, Cline has consulted on a violence intervention/prevention curriculum for Allina Health System and United Hospital's new family residency program. He also is involved with the development of men's support services as part of the Ramsey/Hennepin Initiatives for Violence-Free Families. McLane also helps establish domestic violence screening protocols and provides staff training for personnel at United Family Health Center in St. Paul.

McLane and Cline still work together often, sharing their insight and experience in training and presentations. "From the beginning, we felt it was important to

make presentations together and 'role model' the collaborative relationship rather than just describe it," Cline says.

CELEBRATING SUCCESS

McLane, whose full-time position with SPIP is funded through an ongoing grant from the Minnesota Department of Corrections, is quick to describe the family violence project's accomplishments.

"We've raised the awareness and recognition level in the medical community of the extent of the problem, and we have educated providers that it's a health issue," she says. "Residents from Ramsey Family Physicians are learning about the problem and going on to other communities and practices and spreading that awareness further."

In addition, she says, "We're reaching battered women we couldn't reach before because they were too isolated." SPIP estimates that in 1996 more than 325 women asked for and received intervention, advocacy, and support services after seeking medical treatment at Ramsey Family Physicians.

Still, McLane points out, much more could be done. She would like to see violence intervention/prevention training extended to family physicians and nurses who've been practicing for some time. She also thinks it should be included in medical school and residency curricula for other specialties beyond family medicine.

Both McLane and Cline firmly believe in a collaborative approach to dealing with domestic violence. "Family violence is a societal problem that requires broad expertise," Cline says. "We have the women who need services coming in to the medical system for treatment, but we, as physicians, don't have the expert knowledge of services available, nor the time necessary to guide victims through their options. That's what battered women's advocacy groups do have."

However, McLane says, interorganizational partnerships take a lot of work, and dynamic interaction can easily be brought to a halt by something so mundane as a personnel change. And in an era of increasing consolidation in health care, she hopes that small, grassroots organizations will not be excluded from the discussion.

McLane has become even more aware of the pervasive violence in our culture as she and her husband raise their 2-year-old son. "We've reached so many individuals, but we'd like to change society's reaction in general to domestic violence; the medical community can have a big effect on that," she says.

Cline echoes that sentiment: "When I look into the wide eyes of our 1-year-old daughter, it drives home the need for the medical community to play a strong role in the creation of a world where individuals choose not to govern themselves with violence." MM

Carolyn Griffith is a St. Paul-based free-lance writer who contributes regularly to local, regional, and national publications.



For the past 100 years, we've been creating new stories every day about our care for kids with chronic conditions.

Kimberly's Story

At age 6, Kimberly wasn't able to sit upright when she came to Gillette Children's for treatment for her cerebral palsy.

But with the advanced technology at Gillette Children's, with therapy at the hospital and at home, and through sheer determination, Kimberly learned to walk.

Her adoptive mother says Kimberly, now 11, has stepped into a new world of independence.

Since 1897...

Gillette Children's
Specialty Healthcare

An Essential Community Provider

For more information or a referral, call (612) 229-3851

- Cerebral Palsy and other neuromotor delays
- Spina bifida
- Juvenile arthritis
- Brain and spinal cord injuries
- Epilepsy
- Complex orthopaedic conditions
- Chronic pain
- Technology dependency



ILLUSTRATION BY KATHERINE DUNN

Ask your most difficult and complex patients about personal violence or abuse; you may be surprised.

When Symptoms Defy Diagnosis

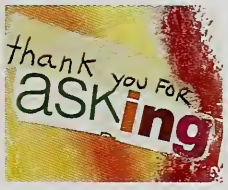
By David McCollum, M.D.

We are taught in medical school to recognize patterns of disease and illness. As residents and young physicians, we hone these skills so that we can rapidly identify patients with new onset diabetes, unstable angina, inflammatory bowel disease, multiple sclerosis, and myriad other conditions that often present in classical ways. But the patterns we are rarely taught, and those we almost never recognize, are the presenting patterns of patients who have experienced personal violence or abuse.

I began to recognize these patterns after several years in family practice. I noticed that some patients' complaints seemed to defy diagnosis, that the patients never got better no matter what care I provided. Yet, their overall health did not deteriorate over time. With some patients, the symptom complex simply did not match any diagnosis that made sense. I started asking questions that went beyond the usual thorough history. When I started asking about violence and abuse, many patients gave positive answers. And the more I asked, the more violence I found. Eventually, I was seeing at least one patient a day who had a history of personal violence that seemed, in some way, to relate to his or her presenting complaint. My patients most commonly reported childhood sexual abuse, but many had experienced physical abuse, verbal abuse, and domestic violence.

Five years ago, I became a full-time emergency physician. The same patterns emerged in the emergency department, and the same questions elicited the same answers. Although I found it more difficult to establish patients' trust in a single emergency visit, it is still possible. The cases that follow are examples of patterns I saw.

A 32-YEAR-OLD MAN was visiting a counseling center to learn anger control when he suddenly experienced atypical chest pain and was brought to the emergency department by ambulance. After ascertaining that his problem was not life-threatening, and was probably not of cardiac origin, I asked the patient questions that uncovered a childhood filled with physical, sexual, and verbal abuse. He had never before been asked about this history, despite years of chemical dependency treatment and counseling for anger management and domestic violence. When I told him that his problems with anger control might be related to his past abuse, he cried and said he had closed those doors long ago, hoping never to reopen them. He was, however, willing and eager to return to his counselor with this new insight. His chest pain was gone. The symptom and behavior pattern was there for years, but no one recognized it. No one asked; no one broke the cycle.



A 20-YEAR-OLD WOMAN with chronic pelvic pain presented with anger and frustration because she had experienced pain in her abdomen every day for months. She had already seen her family physician, an internist, a gynecologist, a gastroenterologist, and a urologist. She had all the tests that seemed appropriate, including ultrasound, laparoscopy, IVP, and barium enema, yet there was still no answer and no relief from her pain. When asked whether she had ever experienced abuse—physical, sexual, or verbal—she answered, "All three." She had never told anyone before because "no one asked." After talking about these issues, I sent her home with a plan to tell her family doctor about her history and to seek counseling at a local crisis center. The symptom pattern was there all along, but five physicians never recognized it.

A 22-YEAR-OLD MAN had been placed on Social Security disability because of fibromyalgia, chronic fatigue, and chronic pain. He presented to the emergency department because he could hardly get out of bed or walk. The physical exam and laboratory tests were unrevealing, so I asked him about personal violence and abuse. He said he could not remember what had happened to him as a child, but his relatives had told him that he was severely abused by a grandfather. Again, the pattern was there: multiple symptoms that are difficult to diagnose and that respond poorly to medical management. But no physician had ever asked about violence or abuse.

A 25-YEAR-OLD WOMAN was brought by ambulance from work with total body "paralysis" and diffuse pain. Her history revealed that a former co-worker was stalking her. When she shared her concerns at work, her colleagues laughed. Like many other patients who have ex-

Behavioral patterns associated with a history of violence or abuse

- Self-mutilation
- Suicide attempts and depression
- Drug seeking and chemical dependency
- Chronic dissatisfaction
- Fear of physical examination
- Hypochondriasis
- Doctor shopping

Physical conditions that can be related to a history of violence or abuse when the physical exam and laboratory tests are normal

- Chronic atypical headaches
- Fibromyalgia
- Chronic fatigue
- Eating disorder, including morbid obesity and anorexia
- Chronic pelvic pain
- Palpitations
- Anxiety or panic disorder
- Multiple unrelated drug allergies
- Irritable bowel syndrome



perienced personal violence, she had symptoms that didn't fit with a known disease, along with a negative physical exam and normal laboratory work. Her doctors thought she had a strange autoimmune disorder.

THEN THERE WAS THE 48-YEAR-OLD WOMAN with chest pain, palpitations, shortness of breath, and nausea. After a negative physical evaluation, she admitted she was afraid to return home to an abusive spouse who would be angry she had sought medical care. Or the 52-year-old woman who returned to the emergency department frequently with work-related complaints, despite modifications of her work site, change in position, and physical therapy with work hardening (a process of gradually acclimating an employee to the physical demands of the job). When finally asked, she admitted experiencing daily verbal abuse from her spouse. After seeking counseling, she returned to the ED to express her gratitude that someone had asked her about abuse.

These are not isolated or infrequent events. The waiting rooms of our clinics and emergency departments are filled with similar stories every day. In most cases, they go untold simply because we never ask. And we never ask because we have never been taught to do so.

The consequences of personal violence often manifest in patterns of illness or disease that are difficult to diagnose or treat. When those patterns go unrecognized and untreated, our patients become disenchanted with classical medicine and often turn to alternative health care approaches, or go "doctor shopping" in an effort to find relief. The physical and emotional pains that result from violence and abuse usually do not respond well to medications and reassurance.

No matter what the specialty, the patterns are there. We must be willing to learn and understand these patterns if we are to avoid misdiagnosis. And we must be willing to ask questions if we are to help some of our most difficult and complex patients. MM

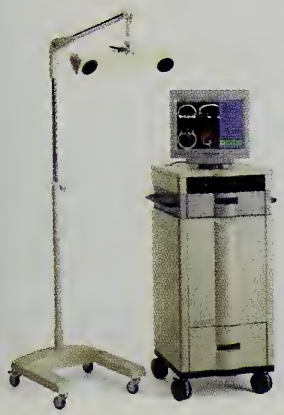
David McCollum is an emergency physician with Emergency Physicians and Consultants, P.A., of Waconia, Minnesota, and a board member of Physicians for a Violence-Free Society.

For a list of suggested questions to ask patients and further discussion of the symptoms of abuse, see the Clinical & Health Affairs article on page 26.



"This is possibly the best operative tool since the microscope."

Dr. William Himango, Neurosurgeon
Duluth Neurosurgical Institute, 218-733-2450



And St. Luke's Hospital in Duluth is proud to be the first to bring it to Minnesota. During his 20-year career as a neurosurgeon, Dr. William Himango has dreamt of the day when technology would enable him to see beyond the view of his operative microscope. That day is here. With the help of a new computerized image guided surgery system at St. Luke's Hospital, Dr. Himango can virtually see through tissue as he operates to remove tumors from the brain and spine. For Dr. Himango, it's a dream come true. For his patients, it means pinpoint accuracy and, ultimately, peace of mind.

St. Luke's
Hospital & Regional Trauma Center

Treating the Batterer

HELP *for* MEN WHO HURT

Are men who batter trying to dominate women, or are they suffering from childhood wounds? Programs differ on what makes abusers tick and what makes them well.

Baltimore

"I grew up in a violent home," says "Doug," a 26-year-old laborer from Hutchinson. "It was pretty gruesome. All my memories are of my mom getting whacked. Several times a gun went off in the house while they were struggling. I was abused, too. I remember getting thrown down the stairs. My mom says I used to barricade myself in the closet. I swore I'd never turn out like that. ... But I guess I did."

Last year Doug was convicted of third-degree assault on his wife of two years. She'd found phone bills showing that he'd been calling his ex-girlfriend, who is raising the son he fathered at age 17. The argument escalated and Doug's wife hit him in the face. "I just exploded," he says. "Broke her nose. Cracked a couple ribs. I was choking her, her eyes were popping out of her head, and I thought, 'Holy %&$#!' "

If there's such a thing as a typical abusive husband, Doug may be close to it. Twenty years after the first group treatment programs for batterers began forming, there's some consensus about who is most likely to become a batterer. "The No. 1 factor is having witnessed domestic abuse as a child. That's one of the few [predictors] that consistently shows up," says Jeffrey Edleson, Ph.D., a social work professor at the University of Minnesota and director of its Higher Education Center against Violence and Abuse. Edleson also has treated batterers in his role as research and evaluation director at the Domestic Abuse Project in Minneapolis.

Although abusers tend to be less educated and have lower incomes than the population at large, abuse occurs in all kinds of families, says Dave Decker, M.A., L.P., a Twin Cities psychologist who works with batterers. "One of the myths is that it's a lower-class phenomenon. I see a lot of guys who make a couple hundred thousand a year—CEOs, attorneys."

Many batterers have shown violent tendencies since childhood, adds Decker. "These guys have lots of problems with fights in bars, fights in the military, fights at keggers, and violence with a previous partner."

As to *why* men batter and what constitutes effective treatment, the consensus evaporates. On one side is the feminist power/control model that says men batter because they've been socialized to equate masculinity with dominance over females. On the other side is the view that men batter because they've been hurt or damaged;

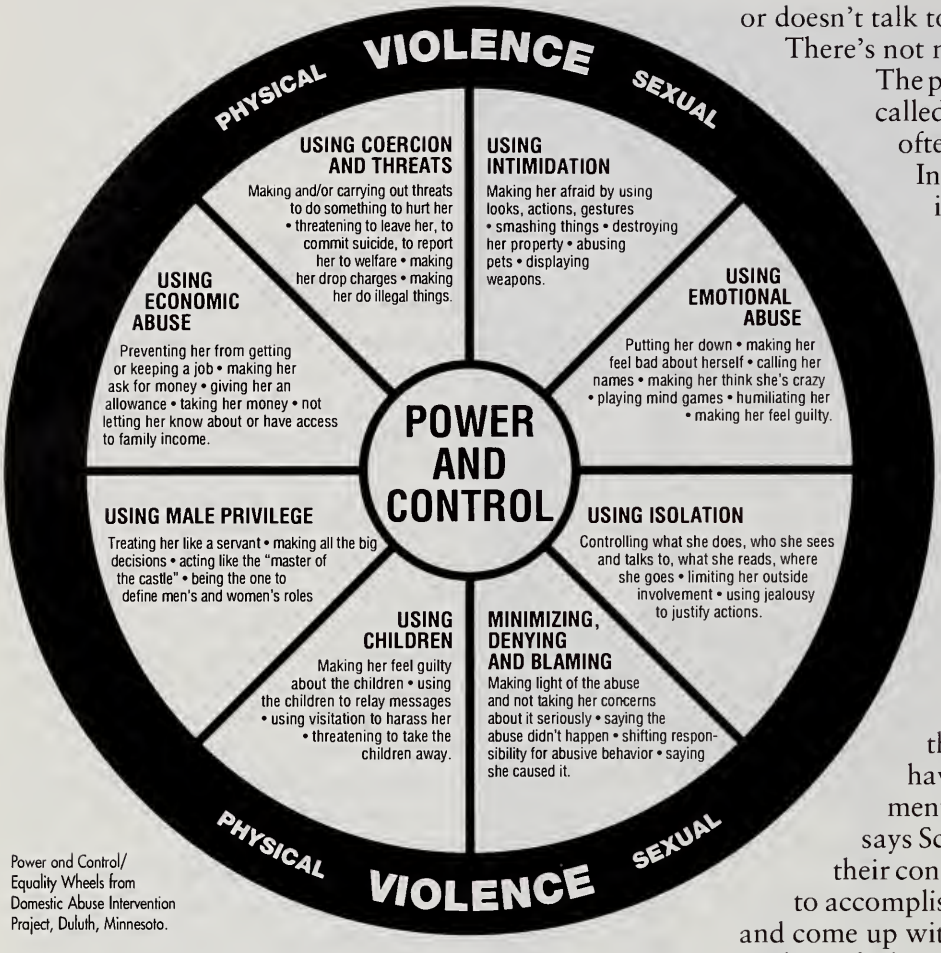
by Kim Palmer







ILLUSTRATIONS BY ALEX HACKWORTH



Power and Control/ Equality Wheels from Domestic Abuse Intervention Project, Duluth, Minnesota.

since they haven't learned constructive ways to recognize and deal with their feelings, they lash out in anger instead.

"It's a big controversy," says Edleson. "The issue is whether men who batter have trouble controlling their anger, or whether they're using anger to control other people. The anger-management model views men as out of control." Edleson, for one, disputes this theory. "That view denies their responsibility. They're not out of control; it [anger] is used purposefully to reinforce their control."

FEMINIST TREATMENT MODELS

Different theories about why men batter have resulted in varied approaches to treating batterers. Some programs emphasize anger management, education, and egalitarian values, while others try to help men identify and express feelings.

"Nobody knows what treatment works or exactly what constitutes success," says Joan Bilinkoff, L.I.C.S.W., M.P.H., an adviser to the Family Violence Prevention Program at HealthPartners, who has counseled batterers. "For some men, getting arrested works. But let's say he stops hitting her and starts torturing her emotionally or doesn't talk to her for three days. Is that a success? There's not much agreement."

The power/control model of treatment, also called "the Duluth model" because it is often associated with the Domestic Abuse Intervention Project (DAIP) in Duluth, is the most widely accepted, says Edleson.

This model relies on the "Power and Control Wheel" (see left) to help men identify behaviors that are abusive, including intimidation, isolation, emotional abuse, and use of male privilege. There is also an "Equality Wheel" (see facing page) to help men identify egalitarian values, such as shared responsibility, trust, and respect.

"We've refined the program over time," says Ty Schroyer, men's violence program coordinator for DAIP. The 33-week program asks men to keep a "control log" in which they record instances of controlling behavior. "We used to use anger-management logs but we've gone past that now," says Schroyer. The men are asked to analyze their control log, discuss what they were trying to accomplish through their controlling behavior, and come up with noncontrolling alternatives.

The Duluth model also seeks to create "an umbrella of safety" by influencing community response to domestic abuse, says Schroyer. DAIP provides training, informational meetings, and consultation with law enforcement officers, prosecutors, and public health employees to build consensus on procedures and develop a unified community approach to the problem.

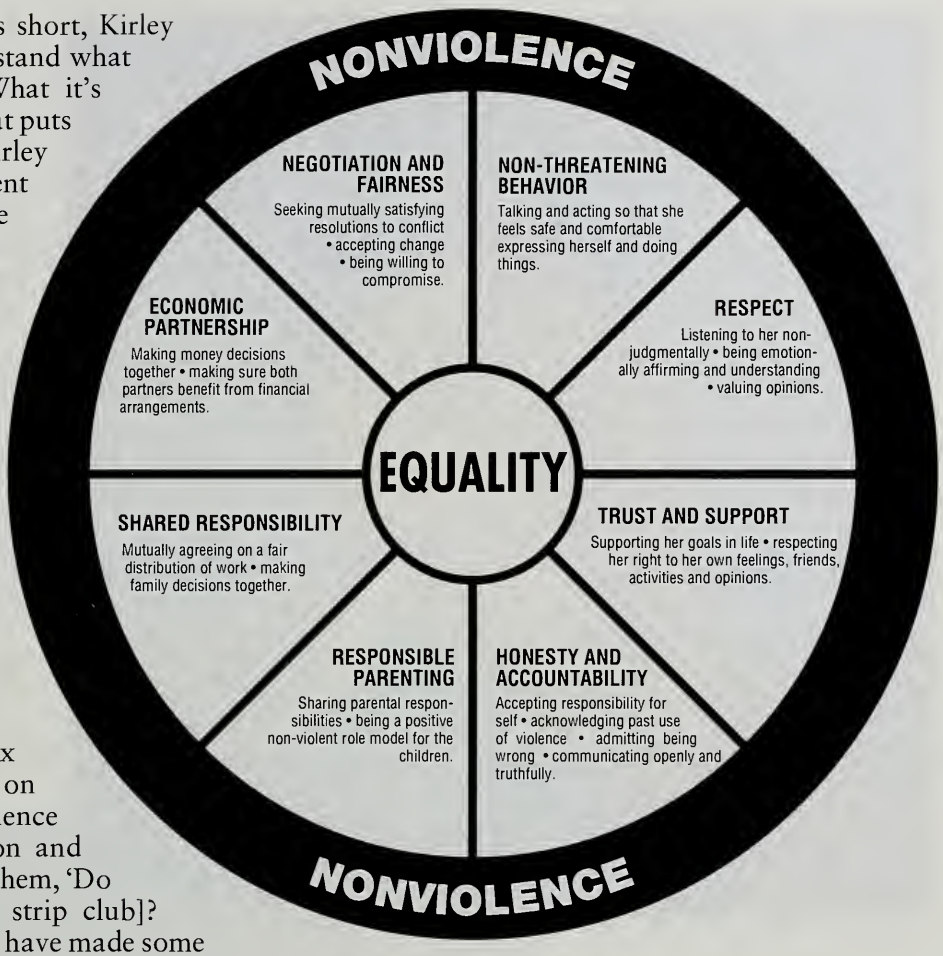
For example, DAIP trains police officers to be more aggressive in arresting abusive spouses. "It helps officers understand that arresting someone for domestic violence can be the best thing for him," Schroyer says. "Even if the children and partner don't want him to go, you're really doing him a favor. You're giving him an opportunity to deal with his problem. If you walk away, it will occur again."

Another treatment group that takes a feminist approach is MESA (Men Stopping Abuse), a Shakopee-based program that offers long-term group therapy for men who batter. MESA doesn't consider its clients successfully treated until they've renounced all abusive behavior, including verbal abuse, says founder and director Kevin Kirley, M.S., L.P. "We expect a lot of our clients. We go well beyond physical violence, all the way down to emotional, psychological, and verbal abuse. We don't make a distinction between those." He sees these different forms of abuse as part of the same continuum.

Anger-management therapy falls short, Kirley says, "because it tends not to understand what domestic abuse is truly about." What it's about, Kirley believes, is a culture that puts women in a "one-down position." Kirley estimates that 30 percent to 40 percent of men are responsible for at least one incident of violent or abusive behavior. "It's extensive and pervasive. Men say, 'I call her names, but that happens in every marriage.' We've normalized so much violence and abuse. The fact that it's normal is the problem.

"Men from nurturing, violence-free backgrounds are equally capable of acting out when push comes to shove, with tremendous devastating consequences," says Kirley. "Just having a blue blanket in the nursery places one at risk."

MESA challenges men to challenge society, Kirley says. The last six to eight weeks of the program focus on understanding socioeconomic violence against women, such as prostitution and pornography. He explains, "We ask them, 'Do you go to Dejavu [a Minneapolis strip club]? Subscribe to *Playboy*? If so, you may have made some changes but you continue to be part of the problem, not the solution."



POWER VS. POWERLESSNESS

On the other end of the treatment spectrum is the "compassion-based approach" developed by Maryland social worker Steven Stosny, Ph.D. Stosny's Compassion Workshop trains abusers to develop compassion for their partners and themselves. "We stress healing, not punishment," Stosny says. "Our view is that people only abuse when they feel powerless. We differ from the power/control model that says men are socialized to dominate women. That doesn't explain gay and lesbian abuse or men who aren't abusive."

In Stosny's view, "gender is an accidental variable" in domestic violence. Abuse, he believes, stems from an "attachment disorder." Abusers often feel inadequate and unlovable, Stosny says. When they fail to deal with those difficult feelings, the feelings resurface as anger. "The fight-or-flight response acts as a pain reliever," Stosny says. "It numbs the pain but keeps you from healing. When we are hardened to our own hurt, we become hardened to others.

"I don't think it has anything to do with patriarchy," Stosny continues. "I've worked with more than 1,000 abusers, and I've never met one who was proud of hurting someone he loved." But Stosny does believe abuse is linked to gender roles. "We teach little girls to regulate their emotions by talking. When women feel unlovable, they call a friend. Men can't do that with other men."

Unemployment is a big predictor of domestic violence, says Stosny. "When people feel bad about themselves, they're more likely to use violence. Provider anxiety is very strong for males.

"The power/control model is not treatment at all," he adds. "It's 'Just Say No.' They confront men and invalidate their feelings of being a victim. We confront them and say, 'Yes, you're a victim—of the way you see yourself.' It's about healing, not about being bad."

Stosny, a former playwright, grew up in an abusive home. "My father would rant and drink heavily. To the world, he would seem to be a monster. But I could see the pain underneath."

Stosny's 12-week program, which includes 43 written homework assignments, focuses on developing compassion for how a spouse and children feel when they live with an abuser and on techniques for regulating emotions.

While MESA teaches that male dominance is inappropriate, Stosny's compassion therapy allows for the fact that some people believe in male dominance for a



variety of reasons, including religious beliefs. "Our population is mostly African-American, and we see a lot of converted Muslims," Stosny says. "Many still believe [after treatment] that the male is the head of the household. But they are able to share, to be more egalitarian, and to feel compassion."

Other programs take the position that even clients from male-dominated cultures can benefit from a dose of feminism. La Opportunidad, a St. Paul-based program that offers Spanish-speaking groups for batterers, uses the Power and Control Wheel, says Maria Espeche, who supervises the program. "Most of our clients are from Mexico," she remarks. "Sometimes they're married to American women and have conflict related to the different gender stereotypes in the two cultures. Things that are tolerated in their culture are not tolerated here." For example, calling the police in a domestic abuse situation is more unusual in Mexico, Espeche says.

A HYBRID APPROACH

Some treatment programs, such as Birchwood Centers in Eden Prairie, embrace elements of both approaches.

"The feminist model is very popular and important," says psychologist Dave Decker, the program's founder. "But the mental health issues also need to be addressed. Pure feminists would argue that [this approach] lets men off the hook, but the two pieces have to go together.

"We talk about family of origin and how they learned to be abusive—not to absolve them of responsibility, but to help them see patterns. A lot of guys who came out of abusive, controlling families have long-term, low-grade depression."

"Doug," who recently graduated from MESA after 50 weeks of treatment, sees value in both approaches. His unhappy childhood did have a profound influence on him, he feels, "but blaming [my behavior] on the way I was brought up is a cop-out." Although he never hit his wife before the assault last year, he says, he threatened her. "I threw a fist past her, close enough to scare her. I made sure that fear was there."

During his first few months of treatment, he admits he wasn't wholeheartedly trying. "I guess I didn't think I needed it. I thought, 'I ain't that bad. She hit me first. That makes it all right.' Then all of a sudden a light clicked on. I thought, 'I've got a chance to better myself.' I started opening up and feeling better. My wife has seen a big change in me the past few months. I can't say I haven't gotten angry, but I can feel the anger signs—clenching my fists—and when that happens, I take a time-out. I say, 'I've got to go for a walk.' It does wonders."

For Doug, the most helpful part of treatment was the check-in period, he says. "The other guys would talk for five minutes; I'd talk for half an hour. I enjoyed that. I could talk and people would listen. My whole growing up process, it was always, 'Shut the @#$% up!' "

He now sees the assault on his wife as "the ultimate control—'I'm the boss, this is my house, I can make the calls I want.' Now I can handle not being the one in control. Now it feels good not to be in control sometimes."

DEFINING SUCCESS

In 1990 and 1991, Edleson conducted a study to analyze the relative effectiveness of group treatments for men who batter. About 250 men were randomly assigned to two differing intensities of treatment. Some were assigned to a program of 12 sessions over three months, while others were assigned to 32 sessions over four months. Within each set, men received either a highly structured educational program, an unstructured self-help format, or a program that combined self-help with education.

The study found that two out of three men assigned to structured education programs or a combination of education and self-help were reported as not violent by their partners in follow-up interviews six months and 18 months after completing treatment. Of the men assigned to self-help sessions only, less than half were reported to be violence-free by their partners, Edleson says.

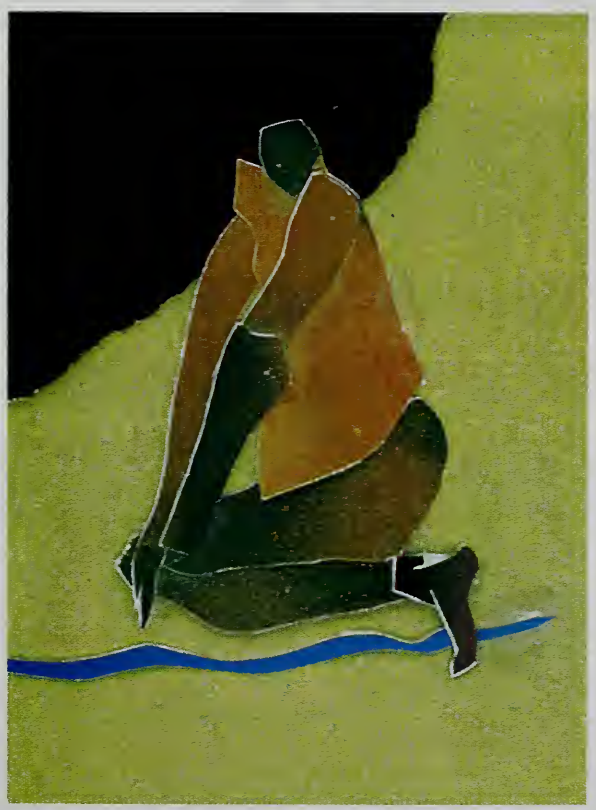
"Generally, the better research shows that education and psychological treatment with education are more effective. It really is a relearning process," explains Edleson.

But sharing thoughts with other men also has a role, he says. "The men who took part in an educational program also went out and talked among themselves afterwards, so self-help and sharing seem to be an important part of the group process."

Stosny claims that 86 percent of those who complete his Compassion Workshop are violence-free after one year, based on calls to their victims. Seventy-three percent are also "verbal-abuse-free," he says.

THE PHYSICIAN'S ROLE

While some health care providers screen victims of domestic abuse, there are no guidelines for screening perpetrators, says Joan Bilinkoff of HealthPartners. "It will be a long time before the medical profession starts to screen men [for domestic abuse]," she says.



Without appropriate training, it's risky for doctors to try to intervene with abusers, she says. If physicians ask questions that suggest they suspect a patient may be abusing someone, the patient may retaliate against his wife or children. For now, Bilinkoff says, it's best for physicians not to confront suspected abusers. If a doctor believes that some action should be taken, he or she can provide information such as resource or hotline phone numbers.

On the other hand, if a patient tells her doctor she's been abused by her partner, "believe her," says psychologist Dave Decker, who has trained health care providers to work with victims of domestic abuse. "Don't say, 'I know your husband and I can't believe he's that kind of man.' "

Decker continues, "It's very important for doctors, if they run into a suspicious situation with a woman, to let her know it's OK to talk about domestic abuse. They shouldn't take a simplistic attitude of 'Leave the jerk!' "

It's more effective to ask questions, Decker says. "Not 'Is he abusing you?' but 'What happens when you and your husband fight? Do you feel fearful when your husband gets angry? Does he ever grab you? Push you?'

"Encourage her *and* let her know help is available, for her and for him," says Decker. There are resources that can help her decide whether to leave. "This is something that can be treated. He can change if he's willing." MM

Kim Palmer is a free-lance writer in Minneapolis.

Suggested Reading

Caesar L, Hamberger K, eds. Treating men who batter: theory, practice, and programs. New York: Springer, 1989.

Edleson JL. Controversy and change in batterers programs. In: Edleson JL, Eiskovits ZC, eds. Intervention with battered women and their families. Thousand Oaks, California: Sage, 1996:154-69.

Edleson JL, Tolman RM. Intervention with men who batter: an ecological approach. Thousand Oaks, California: Sage, 1992.

Palmer SE, Brown RA, Barrera ME. Group treatment programs for abusive husbands: long-term evaluation, 1992. American Journal of Orthopsychiatry 1992;62: 276-83.

Pence E, Paymar M. Education groups for men who batter: the Duluth model. New York: Springer, 1993.

Roy M. The abusive partner: an analysis of domestic battering. New York: Van Nostrand Reinhold, 1992.

Tolman RM, Edleson JL. Interventions for men who batter: a review of research. In: Stith SR, Straus MA, eds. Understanding partner violence: prevalence, cause, consequences and solutions, 1995. Minneapolis, Minnesota: National Council on Family Relations, 1995: 262-73.

Sharing a Vision

A vision of the health care system of the future exists today at Chisago Health Services - where the physicians and hospital have been fully integrated since 1986. And now, we have joined the Fairview Health System of the Twin Cities.

We offer board-certified/eligible physicians the opportunity to work with a progressive, multispecialty medical team in a land of lakes only 35 minutes from Minneapolis and St. Paul.

Our 25 member medical staff has openings in the areas of:

Family Medicine
Orthopedic Surgery
OB/GYN
General Surgery
Psychiatry
Podiatry

CHISAGO HEALTH SERVICES
A subsidiary of Fairview

Please contact:
Physician Recruitment and Retention Department
2450 Riverside Avenue
6A West Building
Minneapolis, MN 55454
1-800-842-6469

Family Practitioner

Western Wisconsin family physician group of ten is interested in adding a full-time, full-range BC/BE family practitioner to their thriving rural practice. A current Wisconsin license (or ability to obtain one) is required. Stress test, colposcopy and OB ultrasound skills preferred.

HealthPartners Ramsey Clinic-Amery physicians enjoy a private-like practice setting with the security of being part of HealthPartners - including access to specialists and services of the St. Paul-Ramsey Medical Center. HealthPartners is one of the largest healthcare organizations in the Midwest, serving over 700,000 patients in Minnesota and western Wisconsin. The clinic is located in charming Amery, WI and is connected to the Apple River Hospital, a 35-bed rural community hospital.

Forward your CV to: HealthPartners Physician Services, Attn: Sandy Lachman, P.O. Box 1309, Minneapolis, MN 55440. Or fax to (612) 883-5395. For more information, call (612) 883-5338 or email: sandy.j.lachman@healthpartners.com. *Amery, WI is not a HPSA area and does not qualify for visa waiver status.* EO/AA Employer.

HealthPartners
Ramsey Clinic-Amery
HealthPartners' mission is to improve the health of our members and our community

At many hospitals, physicians battle every day with things invisible to the naked eye.

At North Memorial, we think you should spend less time worrying about your career and more time worrying about your patients. That's why we believe in policies that are also beneficial to Internal Medicine and Family Practice Physicians. If you'd like to practice in a truly innovative medical community in Minneapolis or a surrounding suburb, call a Physician Placement Coordinator at 1-800-275-4790.

Such as hospital policies.

© 1995 North Memorial

North Memorial

Diagnostic and Treatment Guide for Domestic Violence

The following information is drawn from the AMA "Diagnostic and Treatment Guidelines on Domestic Violence" and information provided by Susan M. Hadley, M.P.H., executive director of WomanKind, Fairview Health System.

How Do You Identify Family Violence?

- Routinely screen for abuse.
- Ask the right questions.
- Be alert for red flags.

ASK THE RIGHT QUESTIONS

In case of injury, interview the patient alone and ask a direct question:

- Did someone hurt you? Did you get these injuries by being hit? In case of anxiety or symptoms of depression or a suicide attempt, ask: What seems most overwhelming in your life right now?

Follow up with the questions suggested for a routine assessment.

In a routine assessment, begin by explaining that you ask all patients these questions as part of their medical history.

- Are you (have you ever been) in a relationship in which you felt you were badly treated? In what ways?
- Has your partner ever prevented you from leaving the house, seeing friends, getting a job, or continuing your education?
- Does your partner try to control your behavior? In what ways?
- We all fight at home. What happens when you and your partner fight or disagree?
- Has your partner ever threatened you?
- Has your partner ever destroyed things that you cared about?
- Has your partner ever threatened or abused your children?
- Has your partner ever forced you to have sex when you didn't want to? Is it OK to say no?
- You mentioned your partner uses drugs/alcohol. How does he act when he is drinking or on drugs? Is he ever verbally or physically abusive?
- Has your partner ever pushed, shoved, grabbed, hit, or slapped you?
- Do you feel that you have to "walk on eggshells" around your partner?
- Have you ever been hit while you were pregnant?
- Do you ever feel afraid of your partner?
- Do you have guns in your home? Has your partner ever threatened to use them when he was angry?

BE ALERT FOR RED FLAGS

- Suspect domestic abuse if the patient has attempted suicide or shows symptoms of depression or anxiety. Mental health problems such as panic attacks, sleeplessness, suicidal feelings, alcohol or drug abuse, post-traumatic stress reactions, feelings of isolation, and inability to cope may be signs of domestic abuse.
- Inquire more closely if the patient denies abuse but has unexplained injuries or if the explanation of how an injury occurred seems implausible. Be alert for discrepancies between the patient's story and her injuries. Look for bruises, lacerations, fractures, or multiple injuries in various stages of healing.
- Common injuries for battered women are in the face, back of the head, chest, breasts, abdomen, and genitals. There may be burns, whip-like bruises, choke marks on the neck and grab marks on the upper arms. Battery to pregnant women is often aimed at the breasts or abdomen.
- The patient may avoid eye contact, seem agitated, or appear more upset than her injuries would warrant.
- Repeat visits to the emergency room or physician's office with chronic injuries or vague complaints may be a cry for help.
- Be suspicious of considerable delays in seeking treatment. The victim may not be able to go for help until the abuser leaves the house.
- An abusive partner may accompany the patient and insist on staying close. He may be overly solicitous and eager to explain the injury and answer all questions for her.

What If You Discover or Suspect Violence?

- Listen to her. Believe her.
- Acknowledge that violence is wrong. Tell her that family violence is a crime. Nobody deserves to be hit.
- Do not pass judgment on the patient or the person who has hurt her.
- Assure her that help is available both for her and her abuser.
- Tell her she can take these steps to stop the abuse:
  - –join a support group
  - –stay at an emergency shelter
  - –seek legal remedies or advice
  - –seek counseling
- Ask: Are you safe right now? Where will you go after you leave my office?
- Set up a follow-up appointment.
- Accept the patient's timetable. Resist the impulse to go for a quick fix. Victims may need time before they are ready to accept help. Leave the door open.
- Report abuse of children or vulnerable adults to the proper authorities. Consult your local telephone directory for the crisis numbers for adult protection and child abuse/protection in your county. Keep these numbers easily available.
- Document abuse in the medical record. Include physical findings, patient's history and statements, and photographs of the injuries.
- Refer the patient to a specific local source for further help. Her first step may be a support group.

continued

Domestic Violence Referral Numbers

General

DOMESTIC VIOLENCE 24-HOUR METRO CRISIS LINE: 612/646-0994

A 24-hour domestic violence line for counseling and identifying a shelter. Referrals can be made for legal services and to culturally specific programs.

HARRIET TUBMAN CENTER: 612/825-3333
24-HOUR CRISIS LINE: 612/825-0000

Provides shelter, education, and resources to promote violence-free families and communities.

THE INITIATIVE FOR VIOLENCE-FREE FAMILIES AND COMMUNITIES IN RAMSEY COUNTY: 612/266-2404

A community-based effort of more than 300 individuals and 100 organizations working together to end violence in families and communities. Although the focus is on Ramsey County, a number of the action teams welcome participation from throughout the Twin Cities.

MINNESOTA OFFICE OF DRUG POLICY AND VIOLENCE PREVENTION: 612/297-7311

Information clearinghouse and referral source. Provides technical assistance to community groups working on violence prevention issues.

MINNESOTA PREVENTION RESOURCE CENTER: 612/427-5310

A statewide clearinghouse for alcohol and other drug abuse materials, including fact sheets on alcohol-related sexual assault and violence.

UNITED WAY FIRST CALL FOR HELP: 612/335-5000

A free, 24-hour information and referral service to more than 2,200 community organizations, including many that focus on preventing violence and/or provide services to victims of violence.

Battered Women

MINNESOTA COALITION FOR BATTERED WOMEN
800/289-6177 OR 612/646-6177
24-HOUR CRISIS LINE: 612/646-0994

The coalition will put you in touch with emergency shelters, advocacy services, and legal resources in communities throughout Minnesota. Also focuses on specific populations, such as women of color and women with disabilities. Know the name of the programs in your area and keep the phone numbers handy to give patients who need emergency shelter or support. Ask your local programs for brochures to put in your exam rooms, where women may read them in private.

Elder Abuse

SENIOR LINKAGE LINE: 800/333-2433

Call to find out the services available in your local community.

Sexual Abuse

MINNESOTA COALITION AGAINST SEXUAL ASSAULT: 612/872-7734 or 800/964-8847

Provides education and referrals for advocacy. Call the coalition to find out the phone number of the crisis line for sexual violence in your area.

Child Abuse

Call your county child protection agency to report suspected abuse and to find out about the crisis nurseries and support services in your area. Keep these numbers handy. Ask for brochures to keep in your examining rooms.

MINNESOTA CHAPTER, NATIONAL COMMITTEE FOR THE PREVENTION OF CHILD ABUSE: 612/641-1568

This agency provides educational programs and information on ways to detect and prevent child abuse.

GREATER MINNEAPOLIS CRISIS NURSERY: 612/824-8000

Offers crisis intervention and resource referral for families regarding child abuse prevention. Provides emergency care for children newborn through 6 years to prevent neglect and abuse.

Youth Issues

BRIDGE: 612/377-8800

A short-term shelter for youth aged 10 through 17. Provides 24-hour individual, group, and family counseling.

Same-Sex Partner Abuse

DOMESTIC VIOLENCE PROGRAM—GAY & LESBIAN COMMUNITY ACTION COUNCIL: 612/822-0127 or 800/800-0350

GAY & LESBIAN HELPLINE: 612/822-8661 or 800/800-0907

Prostitution and Pornography Victims

PRIDE: 612/728-2062

These programs provide support services for women abused in prostitution and pornography.

Culturally Specific Resources

AFRICAN AMERICAN FAMILY SERVICES: 612/813-0782

Provides counseling, education, and advocacy to women who have been victimized.

AIN DAH YUNG SHELTER: 612/227-4184

A 24-hour emergency shelter for children aged 5 through 17.

ASSISTANCE FOR THE ADVANCEMENT OF HMONG WOMEN: 612/724-3066

Provides social services and education to low-income families and women.

BRIAN COYLE COMMUNITY CENTER (SOMALIAN): 612/338-5282

Offers adult and youth services to the community, including a food shelf program and a leadership activity proram for youth.

COMMUNITY UNIVERSITY HEALTH CARE CENTER (SOUHEAST ASIAN): 612/627-4774 OR 612/627-6885

The Community University Health Care Center provides counseling and social services in Southeast Asian languages.

LA OPORTUNIDAD, INC.: 612/872-6165 OR 612/646-6115

Provides educational resources and training to perpetrators of violence, primarily Latino men. Also works with inmates.

Crime Victims

CRIME VICTIMS REFERRAL LINE: 800/247-0390

Twenty-four-hour referral services for crime victims.

Help for Abusers

If a patient confides that he or she is violent to a child or spouse or elderly parent, tell him or her: "It's never OK to hit someone; in fact, it's a crime. If you are hitting someone you love, stop it and get help. If you hurt family members, you are teaching your children to be violent."

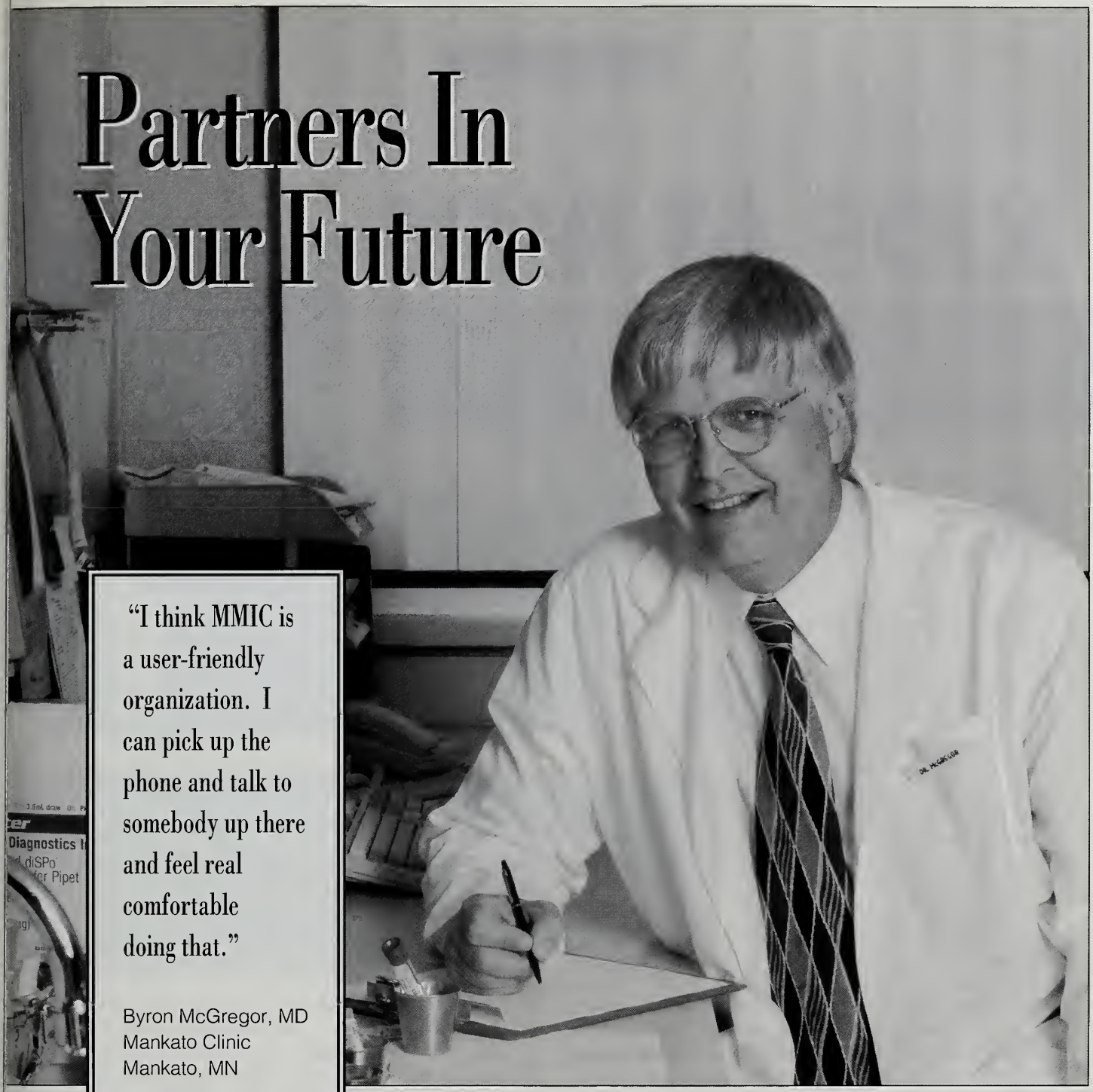
Three of the Minnesota groups that provide education and counseling for abusers are:

DOMESTIC ABUSE PROJECT: 612/874-7063 OR 612/827-0997

DOMESTIC ABUSE INTERVENTION PROJECT: 218/722-4134

FAMILY SUPPORT NETWORK: 612/487-2111

Partners In Your Future



"I think MMIC is a user-friendly organization. I can pick up the phone and talk to somebody up there and feel real comfortable doing that."

Byron McGregor, MD
Mankato Clinic
Mankato, MN

In today's changing medical environment, physicians need to view their professional liability insurer as an important partner in their future. And what better partner can a physician have than a physician-owned and controlled liability insurer such as Midwest Medical Insurance Company. A company that understands a physician's desire to practice the art of medicine.

As your partner, MMIC is here to assist you in your new working relationships and to develop products and programs which improve patient care and lower liability exposures.

MMIC is here for the long term. We bring to the partnership a financial strength of over $251 million in assets and a total equity of over $104 million. Our rating from A.M. Best is A (EXCELLENT).

For a competitive quotation and other information on services offered by MMIC, please call us at 1-800-328-5532.

MMIC

MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S. Minneapolis, MN 55435-1891

KIDS AT RISK

For young adults and children, violence—in the family, at school, on dates—is a serious health and social problem.

By all appearances, Dinah* and Alex* seemed to have the ideal high school romance. Dinah comes from a nice middle-class family and lives in the suburbs. She is athletic and pretty, with lots of friends. Alex is good-looking, a loner, raised in an affluent neighborhood in the city. They attended a safe and nurturing private school. Dinah and Alex seemed to have it all, but appearances often lie.

"From the beginning there were problems," Dinah says. "We didn't even like each other that much when we first started going out. It was more like I wanted a boyfriend and he wanted a girlfriend, so we tolerated each other. ... I thought he was pretty cute, too."

Dinah noticed that Alex experienced "odd mood swings." Still, despite a few bumpy spots, Dinah felt happy with Alex—until she needed some time to deal with a personal tragedy.

"My mom died, and I needed a lot of time to myself," Dinah recalls. "I had to grieve." Alex tried to be supportive at first, but then he lost patience with Dinah's grief. "He got jealous of the fact that I was taking time to myself. He just kind of lost it," she says.

Alex began calling her house at all hours of the day, leaving frightening messages and threatening Dinah. At school one day, he scratched horrible things on Dinah's locker and threatened her in the hallway.

"When I asked him why he'd [vandalized my locker], he shoved me against some lockers," she says.

Alex then shouted, "I'm going to %&@*# kill you, you stupid #$@%!" Their secret was out—the hallway was packed with students on their way to class. Dinah was embarrassed, and finally scared enough to go to school officials. After she told them about Alex's abusive behavior, Alex was suspended.

Helping Young People Cope with Violence

What happened in Dinah and Alex's relationship is happening all over America. Researchers and social workers have become more aware of teen dating abuse in recent years; one researcher estimates that up to one in four dating couples is experiencing abuse[1]. It is just one form of the widespread violence against adolescents and children in the United States. According to the National Institutes of Justice, while adolescents make up only 14 percent of the population age 12 and older, 30 percent of all crimes were committed against them—most often by other adolescents.[2] Teens are at risk of being both victims and perpetrators.

Growing up in a society that glamorizes violence, young adults often do not receive clear direction from peers and adults about how to recognize and handle abusive situations. Aware of the risks, many local and national abuse intervention and prevention programs offer services and programs specifically for young adults and children.

The Domestic Abuse Project in Minneapolis has a program for abusive adolescent males that helps them "unlearn" abusive behavior through structured psychoeducational therapy groups. Most young men are referred to the program through the court system or by police. About 25 young men completed the program in 1996.

"We believe [violence] is learned behavior," says Carol Arthur, executive director of the Domestic Abuse Project. "Almost without exception our boys have grown up within homes where violence occurred. In this society, both covertly and overtly, men get the message that they have a right to control women."

Americans are asking the wrong question, Arthur believes. "Our society asks, 'Why didn't she leave sooner?' Instead, society needs to ask, 'Why are these men abusive?' "

If a young man commits to changing his behavior, the results are good, Arthur says. But, she adds, domestic abuse is getting worse.

Greater Minneapolis Crisis Nursery

Joan Feinberg, a social worker for 33 years, agrees with that assessment. Feinberg is director of family services for Love Lines, an abuse and neglect prevention agency. Love Lines operates the Greater Minneapolis Crisis Nursery, which shelters at-risk children, newborns to age 6, for up to 72 hours.

Feinberg says the kids are brought in for a wide range of reasons: "anything from [a parent's] homelessness and lack of resources to mental illness."



PHOTOGRAPH BY DAN CORRIGAN

Warning Signs of Abuse

If your partner does any of the following, you should seek help:

- hits, shoves, or slaps you
- uses looks or actions to intimidate you
- attempts to control who you see, where you go, or what you do
- calls you names
- humiliates you in front of others.

The crisis nursery is doing everything it can to protect as many children as possible from violence and abuse in the home, but it's a tough mission. "We turn away people all the time because there is so much need and not enough space," Feinberg says. "It's also very difficult to return children to homes where abuse is likely to continue."

Harriet Tubman Center Reaches Out to Schools

The Harriet Tubman Shelter, founded in 1976, was one of the nation's first shelters for battered women. The name change—it's now the Harriet Tubman Center—reflects its wider focus. "We're no longer just a shelter—now we provide shelter *and* education, as well as resources, to promote violence-free families and communities," says Melanie Boulay, a media relations representative for the center.

The center's 16 programs attack the problem of domestic violence in a variety of ways. The School Violence Prevention Program team works to educate youth at Minneapolis public schools, alternative schools, and several Twin Cities colleges and universities. The team uses presentations, films, and counselors to teach students how to identify and prevent or stop abuse.

Mary Blattie, coordinator of the program, is optimistic about its success. "Things are getting better [in terms of awareness]. Students, teachers, and administrators are beginning to realize abuse is not just a female problem, it's a community problem. Abusive behavior is learned behavior, but it can be unlearned."

"Dinah" is one person who has become more aware of domestic violence—the hard way. Now in her last year of high school, she remembers how hard it was to deal with an abusive boyfriend. She doesn't talk to Alex anymore, but she does know he is in counseling and trying to change his behavior.

"I loved him even though he hurt me," she says. "We had some good times together." MM

Ericka Sojourner Davis is a senior at Minnehaha Academy in Minneapolis.

See page 22 for a list of domestic abuse resources.

**The names have been changed to protect confidentiality.*

REFERENCES

1.Tyrrell A. Teen date abuse: prevention and intervention. Proceedings of the 20th Annual Convening of Crisis Intervention; 1996 Apr. 12-14; Chicago.

2.Evaluation of violence prevention programs in middle schools. NIJ Update (Sept. 1995).

BY ERICKA SOJOURNER DAVIS, AGE 17

Domestic Violence

Reality for Some of Your Toughest Patients

Therese Zink, M.D.

ABSTRACT

Until recently, domestic violence was considered a criminal justice or social service problem. However, physicians see victims in emergency settings and clinics with complaints and symptoms that go beyond physical injuries. A study by a Minnesota health plan shows that, on average, a victim of domestic violence costs the health care system $1,434 more per year than a nonvictim. This article discusses the prevalence of domestic violence and the variety of presentations. Guidelines for screening, what to do with a positive response, when to call the police, and how to document and code are reviewed, as are issues unique to older victims of domestic violence.

A 50-year-old woman complains of migraine headaches. She has had a negative workup. Review of her chart shows a variety of somatic complaints throughout the years. She admits that her husband, a family court judge, is emotionally abusive and physically threatening. At one point, she almost called the police.

Historically, domestic violence was considered the domain of the criminal justice system and social services. Until recently, physicians were unaware of the incidence of domestic violence because they did not ask about it. In the past four years a number of physician organizations* and the U.S. Preventive Services Task Force[1] have encouraged doctors to ask their patients about domestic violence. In 1992, the Joint Commission on Accreditation of Healthcare Organizations expanded its guidelines for emergency departments and hospital-sponsored ambulatory care centers to encourage the development of staff education and protocols on domestic violence.

Domestic violence is not an isolated act or event, but rather a pattern of intentional behaviors the perpetrator uses to maintain power and control over the victim. These behaviors can involve physical, emotional, sexual, or social actions (see the power wheel figure, page 16).

Each year, an estimated 11% of U.S. women experience physical or emotional abuse by their current or former partners; as many as 3% experience severe physical abuse.[2] Women are much more likely to be injured by their male partners than are men by their female partners.[3] In a family practice office in Duluth, 45% of the 42 women presenting for routine heath care reported experiencing physical, social, or emotional violence in their current intimate relationships. None of the women were being seen for a preventive exam; their complaints included such symptoms as neck stiffness or migraine.[4]

This article discusses screening for and treating victims of domestic abuse and provides examples of typical patients and their symptoms. Physicians can play an important role in ending domestic violence.

Health Care Costs

It is difficult to estimate the true dollar cost for providing direct medical care to victims of domestic violence, but is thought to be in the range of $1.8 billion per year in the United States.[5] Preliminary medical and mental health cost data on 126 domestic violence victims (average age 38 years), identified at Minneapolis-based HealthPartners by referrals for domestic abuse treatment between 1992 and 1994, showed that the average annual cost of their health care was $3,635. In comparison, a random sample of female HMO enrollees (average age 44 years) had an average annual health care cost of $2,201. The greater costs were attributable to medical clinic visits, hospitalizations, mental health visits, and outpatient referrals (unpublished data, 1996).

How to Ask About Abuse

Just as routine questions regarding a patient's smoking habits identify smoking-related problems and reinforce a patient's decision not to

*For example, the American Medical Association, American College of Obstetricians and Gynecologists, American Academy of Family Physicians, and American College of Physicians.

smoke, routine questions about violence identify abused women, assess their current safety, and heighten the awareness of women who have not been in abusive relationships.[6] Physicians ask questions about intimate health-related issues all the time. Screening for domestic violence simply requires learning to ask about another issue that affects health and knowing what to do when you get a positive answer.

Joan Bilinkoff, adviser to the Family Violence Prevention Program at HealthPartners, recommends health care providers take this approach: Ask open-ended but direct questions (see the sidebar at right). Do not screen with the patient's partner in the room. Make a "one adult patient per exam room" policy. Have materials about domestic violence available in the exam room.

Studies show that physicians do not ask patients about abuse because of time constraints, lack of training, fear of offending the patient, feelings of inadequacy, frustration with the issue, and close personal identification with the patient.[7]

What to Do for Patients Who Are Abused

When you get a positive or equivocal response to a question about abuse, validate the patient's feelings and support her right not to be hurt emotionally or physically. Have materials from the local domestic violence shelter or advocacy program readily available in your exam room and offer them to the patient. Give the patient a 24-hour crisis phone number where she can get immediate help if she feels unsafe or can obtain more information about the dynamics of family violence. Some hospitals and clinics have on-site domestic violence experts available to the patient and physician by phone or in person. These include Fairview Health System (WomanKind), Unity and Mercy Hospitals in Minneapolis, and St. Cloud Hospital.

When you see the patient at a follow-up visit, be sure to ask how things are at home. Helping the patient understand how domestic violence affects her health is crucial in assisting her to make choices for the future. Never recommend couples counseling[8] or tell her to leave the relationship. The patient needs to make decisions on her own when she is ready.

When to Call the Police

Unlike abuse of a child or vulnerable adult, domestic violence does *not* require mandatory reporting in Minnesota, except in cases involving guns, other weapons, and extensive burns.† Contact the police only with the patient's permission (see "Legal Issues and Remedies for Victims of Domestic Violence," page 47).

Confidentiality

The patient has a fundamental right to confidentiality. Without it, her safety and trust are undermined. Follow these procedures: Screen the patient without her partner or family members present; do not place the patient's chart in an area where the abuser or unauthorized individuals could see it; when discussing the case with other professionals, do so in private; do not call the patient's home to discuss domestic violence without her permission—the partner may be listening in or monitoring calls.

How to Document and Code

Proper documentation is one of the physician's most important responsibilities. Documentation should follow the usual SOAP format (subjective, objective, assessment, and plan). Use the patient's own words to describe the event. Identify the name of the

How to Ask Patients about Domestic Abuse

Sample introductions

"Because abuse and violence are so common in women's lives, I've begun to ask about it routinely."

"Because relationships and home life affect health, I've begun to ask my patients these questions."

Sample questions

"Are you in a relationship in which you have been physically hurt or threatened by your partner (husband)?"

"Are you afraid of your partner?"

"How are things going in your relationship?"

"We all have disagreements with our partner at times. What happens when you and your partner fight or disagree?"

Sample questions regarding injury

"I see many women with injuries like yours. Some of them are being hurt by someone they are close to. Is this happening to you?"

"Did someone do this to you?"

"This looks like (fingerprints around your neck, choke marks, a bruise in the shape of a fist, etc.). Did someone do this to you?"

Sample response

"I am sorry that this is happening to you."

"You don't deserve this."

"There is help available if you want it."

---

†**Minn. Stat. § 626.52, Subd. 2:** A health professional who treats, dresses, or bandages a bullet wound, gunshot wound, powder burn, or other injury caused by the discharge of a firearm must immediately report. Wounds believed to be inflicted by any other dangerous weapon (defined by **Minn. Stat. § 609.02, Subd. 6,7,7a**) must be reported to the police if the health care professional reasonably believes that the patient has committed a crime. **Minn. Stat. § 626.52, Subd. 3:** Severe burns—A victim who has sustained any of the following types of burns should be reported within 72 hours in written form to the state fire marshal: second- or third-degree burns to more than 5% of the patient's body; burns to the upper respiratory tract; or any burn that might result in death.

The Physician's Role in Tracking Injuries: The Importance of E-Codes

By Jill Heins, M.S., and Janny Dwyer Brust, M.P.H.

External causes of injury codes, known as E-codes, provide information in the medical record that helps track the magnitude, costs, and causes of violent and nonviolent injuries. Part of the International Classification of Diseases (ICD-9-CM) coding system, E-codes are vital to injury prevention efforts. However, Minnesota hospitals do not regularly E-code nonfatal injuries.

One objective of the Health Care Coalition on Violence is to encourage Minnesota hospitals to E-code all nonfatal injuries. The coalition, chaired by David Strand, president of Medica Health Plans, has been charged with implementing recommendations from the Governor's Task Force on Violence as a Public Health Problem. The coalition promotes violence prevention and intervention activities by the health care community.

Currently, all metro-area hospitals are using E-codes and submitting the data to the Minnesota Hospital and Healthcare Partnership. Approximately 75 % of February 1997 injury cases seen in metro-area hospitals were given E-codes. The coalition is urging all Minnesota hospitals to provide E-codes for all injuries beginning January 1, 1998.

The Physician's Role in E-Coding

When an injured person arrives at a hospital or an emergency department, a physician records details about the injury in the patient's medical record. This information is coded by a medical information specialist and placed on the hospital's UB92 billing form.

Because E-codes are based on the medical record, it is important that physicians provide specific, complete information. Basically, the physician is responsible for answering the what, where, when, and how of the injury. The information a physician includes can be divided into two categories: cause and intentionality.

- **Identify the cause of the injury:** Describe the circumstances and location of the injury. Was the individual injured by a fall down the stairs or an escalator? Was he hit by a hockey puck? Was she shot by a high-powered rifle while hunting? Was she a passenger in a motor vehicle hit by a train? Was he using a power drill when the bit broke and became embedded in his eye? E-codes are incredibly specific; the more detail about the equipment or product you provide, the more accurate the assigned E-code will be.
- **Note the intentionality of the injury:** Was the patient intentionally or unintentionally injured? What was the relationship of the perpetrator to the injured person? If the intentionality of an injury is not known, document that in the medical record. There is an E-code for unspecified intentionality.

Sometimes the causes of injury are multiple. For example, a woman was arguing with her husband at their home. Her husband pushed her and she fell down the stairs, breaking her wrist. Was this injury caused by the unintentional fall down the stairs or the intentional push by her spouse? In 1996, the ICD-9-CM determined that when several situations occur, the intentional injury takes precedence over the unintentional. It is best for the physician to document all information, however, and allow the information specialist to determine the correct code.

In addition, physicians should note in the medical record any personal protective equipment the patient was using at the time of injury. Although this doesn't assist with assigning an E-code, it does aid other data-collection efforts in Minnesota. Examples of personal protective equipment include seat belts, child restraints, bicycle or motorcycle helmets, sports equipment, personal flotation devices, or protective eye goggles.

The data committee of the Health Care Coalition on Violence has developed presentation materials that explain E-codes, their benefits, and how to collect information. For a copy of these materials, or if you are interested in having a coalition member make a presentation to your organization, contact data committee co-chairs Gretchen Musicant, 612/641-1121; Janny Dwyer Brust, 612/992-3924; or Jill Heins, executive director, 612/576-1825. Materials are available on disk or hard copy.

Jill Heins is executive director of the Health Care Coalition on Violence. Janny Dwyer Brust is director of research at Allina Foundation.

abuser and the abuser's relationship to the patient, if the patient agrees. Include the date, time, place of abuse, and the mechanism of injury. An instant-picture camera should be available in your office to document injuries. Use a body map diagram to indicate physical injuries.

Proper diagnostic coding is important for gathering data about domestic violence. Use the medical or mental health diagnosis code as your primary diagnosis (e.g., rib fracture, migraine headache, or depression). Include a code for abuse as a secondary diagnosis: 995.80 for adult maltreatment or V61.11 for counseling a victim of spousal and partner abuse. You may want to include these on your standard office billing form. However, be sensitive to the patient's concern about confidentiality. Check what happens to billing codes in your clinic before using the domestic violence codes to make sure that nothing is sent to the patient's home identifying the reason for her clinic visit.

In the hospital and emergency department, E-codes (external cause of injury codes) are helpful for identifying the cause of many injuries so preventive strategies can be formulated (see the sidebar, facing page).

Training Opportunities

The American Medical Association has developed the Diagnostic and Treatment Guidelines on Domestic Violence.[9] Continuing medical education programs around the state have begun to educate providers about domestic violence screening and intervention. HealthPartners has a 20-minute video, "Domestic Violence: How to Ask and What to Say."‡ The American Academy of Family Physicians offers a home study self-assessment on family violence.[10] Also valuable are the resource manuals for health care providers compiled by the Family Violence Prevention Fund[11] and Physicians for a Violence-Free Society.[12]

‡To obtain a copy, call 612/883-6745. The cost is $5.

Presentation of Domestic Violence Victims

Victims of abuse present in a variety of ways. Physical injuries are often the most obvious. The chronic somatic complaints and psychological symptoms that come from living with the stress of ongoing abuse are more difficult to identify and will be revealed through routine preventive exams. The following categories provide scenarios and common presenting symptoms.[13]

Injuries

A 32-year-old woman presents to the urgent care center with a ruptured eardrum. When asked how it happened, she reports that her fiancé boxed her ears during an argument.

Symptoms that may signal abuse: Facial injuries (e.g., broken teeth or jaw, ruptured eardrum); central injuries to chest, breasts, abdomen, pelvis, peritoneum; pattern of injury not consistent with history; burns or bruises in unusual locations; injuries at various stages of healing; human bites; repeat visits for minor trauma; delay in seeking treatment; previous assault; and injuries from weapons (old scars or new signs).

Somatic complaints without diagnosis

A 35-year-old woman comes into the clinic after leaving an abusive marriage of nine years. She needs forms filled out for her insurance company. She wants her neurologist to know that her poorly controlled migraine headaches are better since she left her husband. Review of her chart shows that she denied abuse at an earlier screening.

Symptoms that may signal abuse: Chronic pain (e.g., head, abdominal, pelvic, back, or neck), fatigue, insomnia/nightmares, vague complaints.

Sexual problems/ gynecological conditions

A 56-year-old woman comes to the clinic for ongoing vaginal complaints. She has a history of vaginitis with a negative evaluation and is on hormone replacement therapy. When screened for abuse, she reports that her husband has been physically and emotionally abusive for many years. Now her sons are verbally abusive. Her physician of 12 years, who had just started screening patients, was shocked. He never suspected it.

Symptoms that may signal abuse: Unexplained chronic gynecological problems (e.g., vaginitis, pelvic pain), sexually transmitted diseases, pelvic inflammatory disease, reported coercion by partner in sexual relationships, sexual dysfunction.

Psychological problems

A 35-year-old woman is seen by a cardiologist after presenting to the emergency department with chest pain, palpitations, and dyspnea. Her EKG shows sinus tachycardia. Further questioning reveals a history of panic attacks that began after her husband threatened to hunt her down if she ever left him.

Symptoms that may signal abuse: Anxiety/panic attacks, depression, low self-esteem, suicidal ideation/ attempt, eating disorders, tranquilizer or sedative use, "difficult" patient.

Pregnancy issues

A 29-year-old registered nurse, pregnant with her first child, frequently visits her midwife with concerns about pelvic pain. The evaluation is always normal. On further questioning, she states that her husband has been forcing her to have intercourse.

Symptoms that may signal abuse: Extreme worry about health of the unborn child, preterm labor, late or inadequate prenatal care, past pregnancy complications (e.g., spontaneous abortion, first or second trimester bleeding, poor weight gain, preterm labor, preterm birth, low birthweight infant, abruptio placentae), abnormal bleeding, alcohol or drug use, cigarette smoking, poor nutrition.

Behavioral presentation

A 44-year-old teacher leaves the clinic crying after talking with the nurse during a preventive pre-physical evaluation. The patient had disclosed that her husband hit her teenage son to discipline him about going to bed the other night. She said her husband had never hit her, but that he had threatened her. *continued*

Treating Abused Seniors

Women in their late 50s and beyond are often forgotten when physicians screen for abuse because many have been in long-term marriages. The key to successfully treating older abused women is understanding their generational differences and developing a trusting relationship. Many senior women have lived through the Depression, two world wars, and several natural disasters.

The older abused woman was likely raised with different values and expectations. She was probably taught absolute obedience and subservience. Above all, she was likely told that she must never discuss "private family business" with anyone, not even members of her own family. This isolation helped her abuser keep the ugly secret. She has survived years of personal pain alone.

For an older woman, telling anyone about her abuse means taking an extraordinary risk. If she is without independent means, she risks losing her home and financial support. She fears alienating her children and grandchildren. This may be more terrifying than the abuse itself.

Use the following procedures when treating senior women:

- Communicate in a manner that puts the woman at ease and builds trust. Even if you use the best communications skills, the woman may keep silent out of fear.
- Screen the patient alone. Ask her spouse or children to step out of the room.
- The patient's health may be fragile; she may have a variety of physical and mental health problems, so you are probably seeing her in your office regularly. Be sure to screen all your senior patients for abuse, even if you have known them for years and don't consider abuse a possibility. You may be surprised.
- You alone cannot help abused patients. Know the domestic violence advocacy program available in your area and keep resources handy.
- Often senior women do not drive, and the abuser may be her only source of transportation. An alibi for her visit with the domestic violence advocate is mandatory. Coming to see you for a blood pressure, medication, or diabetes check may be the perfect excuse for her to meet with the domestic violence advocate from your area. Identify your local program and coordinate with it.

Acknowledgment

Written with the assistance of Marie Schatzlein of Cornerstone Advocacy Services in Bloomington, Minnesota.

Symptoms that may signal abuse: Crying, minimizing statement, very flat affect, angry or anxious body language, defensiveness, searching or fearful eye contact, comments about emotional abuse or a friend who is abused.

Change in office visit patterns

The receptionists at a family practice clinic attend a training course on domestic violence. After the training, they discuss two patients whose husbands have continually canceled their wives' appointments. One of the women had been seen for a rib fracture.

Symptoms that may signal abuse: Missed or late appointments, appointments canceled by partner, frequent late arrival, sudden increase or decrease in frequency of visits, change to use of emergency room or urgent care rather than office visits, frequent changes of health care provider.

Controlling coercive behavior of partner/companion

A Russian couple in their 30s comes into the exam room together so he can interpret for her annual exam. When the clinic staff discuss the family, the pediatric nurses inform the internist that the woman frequently brings her children in alone and speaks English without difficulty.

Symptoms that may signal abuse: Partner hovers, patient seems reluctant to speak in front of or disagree with partner, partner does not allow patient to obtain or take medication, patient appears fearful of partner—defers to partner to answer questions.

Conclusion

Domestic violence affects the lives of our patients. The most effective role for the informed physician is to identify abuse; offer sensitive care and intervention; inform the patient of available local resources to aid her in seeking safe, viable alternatives to her situation; and document the findings and plan for follow-up. Physicians and researchers have much to learn about the dynamics of domestic violence. With improved skills, training, and experience, health care providers can effectively screen patients and work with community domestic violence resources to help prevent violence in their communities. MM

Acknowledgment

Thanks to Joan Bilinkoff, adviser to the Family Violence Prevention Program at HealthPartners, for her assistance writing this article.

Therese Zink is a family practice physician at HealthPartners. She led the effort to develop HealthPartners' domestic violence initiative.

References

1. Report to the U.S. Preventive Services Task Force: guide to clinical preventive services. 2nd ed. Baltimore, Maryland: Williams & Wilkins, 1996;51:555-65.
2. Straus MA, Belles RJ. Societal change and change in family violence from 1975 to 1985 as revealed by two national surveys. Journal of Marriage and Family 1986;48: 465-79.

continued



75th Anniversary Minnesota Medical Association Alliance

Friday, October 10, 1997
North Oaks Golf Club
54 East Oaks Road • North Oaks, MN

10:00 a.m.	REGISTRATION
10:30 a.m.	SOCIAL TIME/VIEW EXHIBITS
11:30 a.m.	LUNCHEON
12:30 p.m.	GREETINGS Ophelia Balcos, Anniversary Chair Kendra Flanagan, President, MMAA Kent Wilson, M.D., President, MMA
12:45 p.m.	VIDEO PRESENTATION Alliance Through the Years - A Milestone of Accomplishments
12:55 p.m.	INTRODUCTION OF PAST PRESIDENTS Kendra Flanagan
1:00 p.m.	REMINISCENCES Karen A. Tourdot, Executive Director
1:10 p.m.	REMARKS BY NATIONAL REPRESENTATIVE
1:20 p.m.	KEYNOTE SPEAKER Sue Zelickson, WCCO Radio Personality

COST: $19.00

Formal invitations have been mailed. All members and guests are welcome. Don't miss this event!

Credentialing "What If's"

A Powerful New Tool for Credentialing

- Provides a unique, hands on guide to the skills needed for credentialing
- Shows you how to decrease risk and assure the quality of potential providers
- Includes a step-by-step guide to credentialing processes and procedures

Please call (612)992-3095 for more information

CONTINUING MEDICAL EDUCATION

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

OCTOBER, 1997

22 PRINCIPLES OF DIABETES
Presented by: Allina Health System
Location: United Hospital, St. Paul

24 INSIGHTS & OUTLOOKS '97
Presented by: St. Paul Heart Clinic
Location: United Hospital, St. Paul

24-25 GASTROENTEROLOGY CONFERENCE
Presented by: Minnesota Gastroenterology
Location: Marriott City Center, Minneapolis

25 WHAT'S NEW & INNOVATIVE IN CARDIO-THORACIC SURGERY
Presented by: Cardiac Surgical Associates, P.A.
Location:Minneapolis Airport Marriott, Bloomington

NOVEMBER, 1997

21 - 22 NEW ULM FALL SEMINAR
Presented by: New Ulm Medical Center
Location: New Ulm Medical Center, New Ulm

For more information, contact Allina Clinical Education and Research - (612) 992-2424

™ A Trademark of Allina Health System

Visit the Allina CME calendar at http://www.allina.com

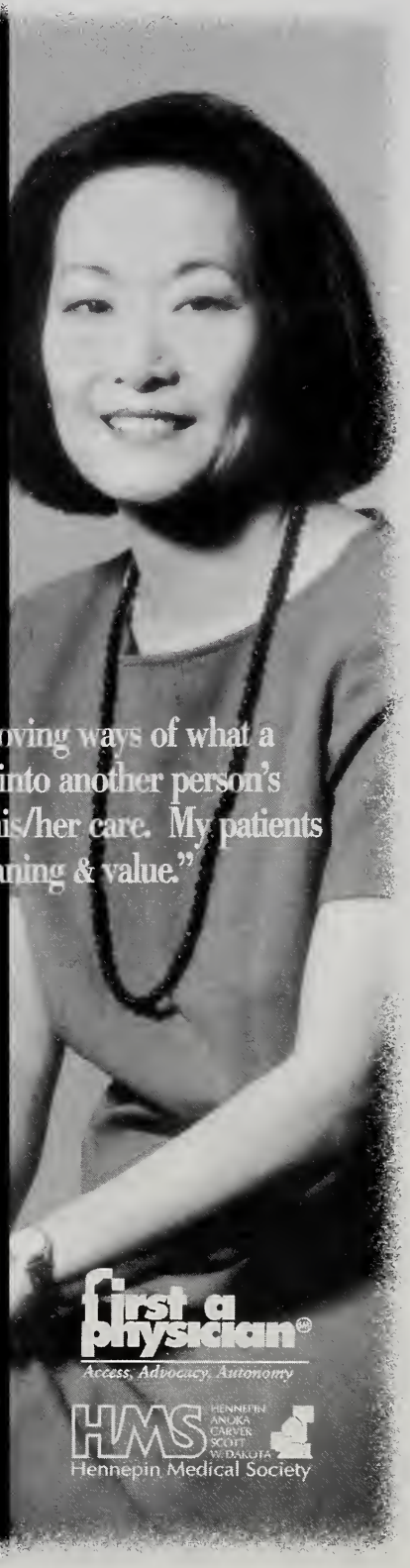
3. Stets JE, Straus MA, eds. Physical violence in American families: risk factors and adaptation to violence in 8145 families. New Brunswick, New Jersey: Transaction Publishers,1990:151-65.
4. Elliott BA, Johnson MMP. Domestic violence in a primary care setting: patterns and prevalence. Arch Fam Med 1995;4(2): 113-9.
5. Miller TR, Cohen MA, Wiersema B. Crime in the United States: victim costs and consequences: final report to the National Institutes of Justice. Washington, D.C.: The Urban Institute and the National Public Services Research Institute, 1995.
6. Flitcraft A. Physicians and domestic violence: challenges for prevention. Health Aff 1993;12(4):154-61.
7. Sugg NK, Inui T. Primary care physicians' response to domestic violence: opening Pandora's box. JAMA 1992;267(23):3157-60.
8. Council on Scientific Affairs, American Medical Association. Violence against women: relevance for medical practitioners. JAMA 1992;267(23):3189.
9. American Medical Association. Diagnostic and treatment guidelines on domestic violence. Arch Fam Med 1992;1(1):39-47.
10. Baker NJ, Mersy DJ, Tuteur JM, Cline JM. Family violence: AAFP home study self-assessment. Kansas City, Missouri: American Academy of Family Physicians, June 1996.
11. Warshaw C, Ganley AL. Improving the health care response to domestic violence: a resource manual for health care providers. 2nd ed. San Francisco: Family Violence Prevention Fund, 1996.
12. Salber PR, Taliaferro E. The physicians guide to domestic violence: how to ask the right questions and recognize abuse. Volcano, California: Volcano Press, 1995.
13. Trezona P, Ernsberger D, Zink T, et al. ICSI domestic violence health care guideline. In: ICSI 1996 health care guidelines. Vol. I. Bloomington, Minnesota: Institute for Clinical Systems Integration, 1996.

" I didn't plan a career in medicine . . . it evolved for me. I started in sociology because I liked studying people, communities and social systems. I was also interested in science. There's a lot of beauty, awe and wonder in the natural and life sciences. Medicine was a way to blend my interest in people with science.

When I was doing graduate research, I worked in a windowless basement room with 5 feet of counter space. One night I had to sleep on the floor of this lab next to a large,temperamental cryoprecipitator that was harvesting frozen DNA samples. I nursed that machine exhaustedly into the following morning. Now, during a sleepless night of call, I am grateful that it is not a machine I am tending."

"I am often reminded in moving ways of what a privilege it is to be allowed into another person's life and be entrusted with his/her care. My patients are what give my work meaning & value."

Karen T. Lucas, M.D.
Family Practice
Apple Valley HealthPartners



first a physician®
Access, Advocacy, Autonomy
HMS Hennepin Medical Society
HENNEPIN ANOKA CARVER SCOTT W.DAKOTA

ASPEN Medical Group

Full Time Urgent Care

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 12 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

The Monitor
News For Minnesota Physicians

Delegates Set Policy at 144th Annual Meeting

Not unexpectedly, smoking-related issues lit up numerous discussions at the 144th Annual Meeting at Madden's Resort in Brainerd on September 14, 15, and 16. Delegates passed several resolutions dealing with tobacco, including Resolution 205 making a ban on the sale of tobacco products to people under age 21 a "high legislative priority."

Resolution 321 was passed encouraging all parents to declare their homes "smoke-free" homes. The MMA pledged to look at creating and distributing materials for physicians to give to patients about the effects of passive smoke exposure on children. The association also will seek legislation requiring day care homes to be smoke-free 24 hours a day, rather than just when children are present, as state law currently dictates.

Days before the annual meeting, University of Minnesota researchers released a study showing evidence of a cancer-causing substance in the urine of nonsmokers who work in smoke-filled rooms. The study suggests that people may develop lung cancer due to second-hand smoke exposure.

Noting the recent surge in popularity of cigars—despite their link to cancers of the throat, mouth, and esophagus—delegates passed Resolution 319 pledging to include them, along with pipe tobacco and smokeless tobacco, in antitobacco campaign efforts.

The MMA also passed Resolution 109 encouraging all members and their practice groups to consider not investing in tobacco company stock—and to consider not displaying magazines with tobacco advertising in patient waiting rooms.

"There is no reason why we should advertise tobacco in our offices," said longtime antitobacco activist A. Stuart Hanson, M.D., president of the Smoke-Free 2000 Coalition.

The resolution also encourages the Minnesota Council of Health Plans to adopt a policy recommending that its members not invest in tobacco company stocks, and it reaffirms existing MMA policy not to invest in tobacco stocks or to accept contributions from tobacco companies.

Impaired Driving

Intense debate preceded adoption of Resolution 208, which asks for legislation to allow physicians to report patients who they have reason to suspect are driving drunk or impaired and to stipulate that physicians would not face a threat of a penalty as long as they acted in good faith.

Delegates arguing against the resolution were concerned about the possibility that patients who know they may be reported to the police may hesitate to seek appropriate care, and the possibility that minority patients may be unfairly singled out—by physicians or police—for blood alcohol testing and arrest.

"Let's not encourage emergency room physicians to be cops in white coats," said committee member Mark Liebow, M.D.

But delegates who supported the

Policy continued on page 34

Announcements

New Officers Elected

The MMA House of Delegates elected the following officers, AMA delegates and alternates, and trustees at the MMA Annual Meeting.

President-elect:
Judith F. Shank, M.D.

Vice President:
Anthony C. Jaspers, M.D.

Secretary:
Robert Milligan, M.D.

Treasurer:
Noel R. Peterson, M.D.

Speaker of the House:
Blanton Bessinger, M.D.

Vice Speaker of the House:
Gary Hanovich, M.D.

AMA Delegates:

A. Stuart Hanson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternate Delegates:

Lyle Munneke, M.D.
Thomas Peyla, M.D.
Sally J. Trippel, M.D.

Trustees:

James L. Anderson, M.D.
John W. Larsen, M.D.
Keith D. Larson, M.D.
Paul C. Matson, M.D.
Joseph L. Rigatuso, M.D.

Paul C. Matson, M.D., was elected chair of the MMA Board of Trustees at a board meeting immediately following the Annual Meeting.

October Designated Child Health Month

The Minnesota Medical Association is again teaming up with other organizations to plan activities for October, which has been designated National Child Health Month by the American Academy of Pediatrics.

Policy *continued from page 33*

resolution said that bringing a patient who posed a danger to himself or herself or others to the attention of police would not conflict with the role of patient advocacy.

"What is a patient advocate?" asked delegate Ben Whitten, M.D. He said one intent of the resolution is that a patient who has been drinking and driving will get appropriate treatment before it is too late.

Under the proposed legislation, physicians would not disclose or share results of their own examinations, but could alert law enforcement officials that there is probable cause for police to take blood alcohol tests.

Managed Care

In the immediate wake of Nicole Lurie's report on physician dissatisfaction with managed care (see page 35), delegates passed several resolutions addressing concerns about the involvement of health plans in physician-patient relationships.

The House of Delegates (HOD) passed Resolution 310 vowing that the MMA will establish a "hotline" system for physicians to report inappropriate influence on their clinical decision-making by third-party payers. The MMA also will consider developing a dispute mechanism to be used when third-party payers deny medical care that physicians believe, based on acceptable professional standards, is in the best interest of their patients.

Resolution 308 directs the MMA to determine whether managed care organizations are making timely payments to physicians. If the Board of Trustees ascertains that late payments to physicians are a problem, the resolution calls for the MMA to draft legislation—similar to a law passed in Maryland—to remedy the problem.

Delegates passed Resolution 316 dealing with the pricing of health plan products, partly in response to recent warnings to physicians by some health care systems about a need for increased frugality and possible cuts in physician fees. The resolution urges health care systems to avoid pricing strategies that—while winning the health plans a bigger market share in the short term—create budget shortfalls over the long haul, forcing compromises in services, benefits, access to care, and physician payment.

In Resolution 408, the HOD directed the Board of Trustees to study the application of antitrust laws in negotiations between physicians and health plans regarding various terms and conditions of managed care contracts. The MMA will use the board's study of antitrust laws to develop appropriate related resolutions to bring to the AMA Annual Meeting in June.

And delegates passed Resolution 323 opposing reimbursement arrangements that create undue economic pressure to withhold medically necessary care.

Referred to the Board of Trustees was Resolution 207 recommending study of the Texas state law dealing with the liability of health care plans and analysis of whether such a law might benefit Minnesota physicians.

Clinton: Tobacco Settlement Insufficient

• • • • • ANOTHER MAJOR TOBACCO-related development unfolded shortly after the MMA Annual Meeting, when President Clinton pronounced the proposed tobacco settlement inadequate. He requested five key changes in the settlement—including several that were called for by the MMA in letters to Minnesota's congressional delegation in July.

Among the changes sought by the president—and the MMA—is a requirement that the FDA have full authority to regulate tobacco products, and that tobacco companies release documents on the health effects of their products and their strategies for marketing to kids. The president also proposed that the industry should make payments, plus penalties, if teen smoking does not fall to a targeted level over the next decade.

Because the president's move effectively delays a national tobacco settlement until at least next year, Minnesota Attorney General Hubert Humphrey III's case against the tobacco industry can go to trial on January 19 as planned. Humphrey seeks billions of dollars for the state from tobacco companies to offset Medicaid payments for smoking-related illnesses.

Just hours earlier, the MMA House of Delegates renewed its commendation of Humphrey for his antitobacco efforts and urged Congress to proceed with caution in tobacco settlement legislation. The MMA has worked for years with the attorney general in the Smoke-Free 2000 Coalition.

Sunbeam

Delegates expressed extreme disappointment over the American Medical Association's (AMA) endorsement of Sunbeam commercial products. Resolution 110 stating that the MMA "has taken urgent exception" to the endorsement—which has proven to be a public relations nightmare for the AMA—was easily passed. Resolution 110 also directs the MMA Board of Trustees to convey member concerns to the AMA Board of Trustees and recommends a thorough investigation of how the controversial arrangement was made, with results to be shared with AMA members before the December 1997 Interim Meeting.

The AMA announced a "reorganization" September 19 of its top management team in the fallout over the marketing agreement with Sunbeam. The AMA Board of Trustees issued a statement pledging to publish, for consideration by the House of Delegates, clear, consistent, and enforceable policies to govern the use of the AMA name and logo.

Policy continued on page 36

County-based Purchasing Teleconference Slated

Forty-seven of Minnesota's 87 counties have submitted 19 preliminary proposals to the Department of Human Services to develop county-based purchasing initiatives. About 80 percent of the state's Medical Assistance/General Assistance Medical Care population is represented in the proposals.

The 1997 Health and Human Services bill gave counties authority to develop county-based purchasing as an alternative to the state's Prepaid Medical Assistance Program. Counties that move to county-based purchasing would assume the risk and be responsible for purchasing health care coverage. DHS officials will review the proposals and respond to the counties in November.

The MMA and other health care provider organizations will broadcast a satellite teleconference October 14 to discuss the issues involved in planning county-based purchasing efforts. Every county in Minnesota will host a live broadcast of the teleconference at 6:30 p.m. To find out where a particular county will air the teleconference, contact Pat Biersach at the MMA, 612/378-1875 or 800/342-5662. • • • • •

Dr. Wilson Inaugurated



Newly inaugurated President Kent S. Wilson, M.D., of St. Paul accepts the presidential medallion from outgoing President Raymond G. Christensen, M.D., of Moose Lake at the Inaugural Dinner during the MMA's 144th Annual Meeting in Brainerd.

Physicians Hand HMOs a Poor Report Card

A study revealing that most physicians would not recommend the health plan they work for to their own families was released September 16—as the MMA House of Delegates began to vote on a number of resolutions dealing with quality of health care. Most of the 300 physicians responding to the survey either said they were neutral or disagreed with the statement that they would recommend the plan to their own families. Nicole Lurie, M.D., and Steven Borowsky, M.D., of the University of Minnesota, were the lead researchers on this study rating physician satisfaction with six Twin Cities health plans.

As *The Monitor* goes to press, the report was to be presented at the Midwest Region of the Society of General Internal Medicine on September 26.

"This study is extremely valuable because for the first time it asks for the physician perspective," said newly inaugurated MMA President Kent Wilson, M.D. "I hope this will open the door to a collaborative effort by physicians and health plans to improve quality of care for our patients."

HealthPartners Classic, which pays its physicians at the HealthPartners clinics a straight salary, was consistently rated higher than the others. Blue Plus, which is owned by Blue Cross and Blue Shield of Minnesota and requires members to choose a primary care provider and obtain referrals for most specialty care, received the lowest satisfaction ratings.

The study followed up on a similar study by Lurie and Borowsky published in the September 17 issue of *JAMA*, which did not name health plans. Reacting to that study, Wilson told the Minneapolis-based *Star Tribune* newspaper he was most disturbed by the finding that 16 percent of respondents feared negative repercussions if they criticize their health plan.

"It's important for health plans and physicians to work together in an atmosphere free of fear of retaliation," Wilson told *The Monitor*. He suggested that the study be repeated in a couple of years to see if progress is being made. • • • • •

Dr. Smith Earns Distinguished Service Award



Andrew J. K. Smith, M.D., with his wife Mary Hill, is presented with the Distinguished Service Award at the MMA Inaugural Dinner.

The MMA presented its Distinguished Service Award to Andrew J. K. Smith, M.D., of Wayzata, at the Annual Meeting in Brainerd on September 15. The Distinguished Service Award, the highest honor given by the MMA, recognizes physicians who have made outstanding contributions to organized medicine. Smith is a board-certified neurological surgeon who has been in private practice in Minnesota since 1977.

He began his extensive involvement in the MMA by serving on, then chairing, the MMA Committee on Communications. Other committees on which Smith has served include the Strategic Planning Task Force, the MMA/MHA Liaison Committee, and the MMA Executive Committee.

Smith is perhaps best known for his role in health system reform. He chaired the MMA Board of Trustees from 1990 to 1993. He served on the MMA MinnesotaCare Task Force, was the MMA alternate on the Minnesota Health Care Commission, and served as MMA president in 1994—the year the MMA introduced its Quality and Coverage Act at the state Legislature. An effective MMA spokesperson and leader, he played a pivotal role in shifting the direction of health system reform away from over-regulation.

He chaired the joint committee of the MMA, Hennepin Medical Society, and Ramsey Medical Society that developed the framework for Clinics Without Walls. He served as president of the Minnesota Neurological Society and as president of the medical staff of Methodist Hospital. He has served as a Minnesota delegate to the AMA since 1995. Currently, Smith is board chair of the Midwest Medical Insurance Company.

Smith also was re-elected at the Annual Meeting to serve another two-year term representing Minnesota physicians in the AMA House of Delegates. • • • • •

SART Opens; Stop the Violence Winners Named

Linda Ledray, Ph.D., spoke at an August 19 news conference announcing the opening of South Central Minnesota's Sexual Assault Resource Team (SART) at St. Joseph's-Immanuel Hospital in Mankato. Ledray is founder of the Sexual Assault Resource Services (SARS) at Hennepin County Medical Center. SART is based on SARS; both are collaborative efforts with medical, law enforcement, and advocacy personnel to increase follow-up visits with assault survivors and pursue prosecution. The Minnesota Medical Association, Attorney General Hubert Humphrey III, and Douglas Wood, M.D., president of Immanuel St. Joseph's-Mayo Health System, also were present at the news conference. MMA policy adopted at the 1995 Annual Meeting supports expansion of programs like SARS throughout the state.

Ledray was one of four winners of the MMA's annual Stop the Violence Award, presented in Brainerd at the Annual Meeting. The other winners were the Maple River Community Network, J. Michael Cline, M.D., and Rebecca McLane (see *Minnesota Medicine* story, page 6). • • • • •

Policy *continued from page 34*

"No association of the AMA's name or logo with a company, product or service," read the statement, "will be permitted until the AMA Board of Trustees establishes a clear set of policies, consistent with the AMA's ethical values." Sunbeam Corp. filed a $20 million lawsuit against the AMA after the AMA Board of Trustees announced it was withdrawing from the deal.

For a summary of all of the resolutions, see pages 37-40. • • • • •

1997 Resolutions Address Wide Range of Issues

The 1997 Minnesota Medical Association House of Delegates convened at Madden's Resort in Brainerd on September 15 and 16, taking action on resolutions that will set the MMA's course for the coming year.

Res. 100, The Physician's Guide to Hospice Care

Adopted as amended.

The MMA, with the copyright holder's approval, will promote the second edition of *The Physician's Guide to Hospice Care* on the MMA Web site, and after approving the third edition, will make it available at the MMA office and on the Web site.

Res. 101, Res. 102, Res. 104, and Res. 105, MMA Alliance Funding

Not adopted.

Each of these resolutions dealt with restoring funding for the MMA Alliance. Resolution 106, which was adopted, accomplished this goal.

Res. 103, MMA Annual Meeting Content, Structure and Format

Adopted.

The MMA will appoint an Annual Meeting Task Force of physician members to make recommendations to the MMA Board of Trustees on the future content, structure, and format of the Annual Meeting.

Res. 106, Alliance Funding

Adopted.

The MMA and MMAA will investigate possible further joint activities through a study task force, the MMA will help the MMAA develop and implement a membership recruitment and retention marketing campaign, and the two organizations, through their finance committees, will examine various factors to determine an appropriate conversion factor. The conversion factor will be multiplied by the number of Alliance members for the previous year to determine the amount of financial support supplied by the MMA to the MMAA for that year. For MMAA fiscal year 1997, the conversion factor will be $17.50, making a total MMA contribution of $18,165.

Res. 107, Support of Human Rights and Freedom

Adopted as amended.

The MMA affirmed the AMA policy stating, "Continued Support of Human Rights and Freedom: The AMA continues 1) to support the dignity of the individual, human rights and the sanctity of human life, and 2) to oppose any discrimination based on an individual's sex, sexual orientation, race, religion, disability, ethnic origin, national origin or age, and any other such reprehensible policies." The MMA also will encourage physicians to take leadership roles in their communities to eradicate any such discrimination.

Res. 108, MMA Budget

Adopted as amended.

The MMA voted to maintain 1998 membership dues at the same level as 1997 dues, and approved the proposed 1998 Operating Budget and the 1998 Capital Budget. The MMA also will request that resolution authors include fiscal notes on all requests for MMA resources, based on criteria developed by the Board of Trustees. Finally, the MMA will assess the impact of nondues revenue on the association.

Res. 109, Investment in Tobacco

Adopted as amended.

See page 33.

Res. 110, AMA Policy Decision-Making

Adopted as amended.

See page 34.

Res. 200, Provider Tax Itemization and Appeal Process

Adopted as amended.

The MMA will continue to work through existing coalitions to develop a consistent format for reporting the provider tax, to be used by all third-party payers when making payments to physicians and other health care providers, until the provider tax is repealed. The MMA also will make information available to physicians explaining how to file complaints when third-party payers fail to pay the provider tax. Finally, the MMA will encourage physicians to contact the MMA when they feel the provider tax is not being paid by third-party payers.

Res. 201, Commission on Financing Medical Education

Adopted as amended.

The MMA will take a leadership role in identifying and implementing new strategies to ensure a long-term, stable financing base for medical education in Minnesota. The MMA also will develop strategies to facilitate communication with members of the Medical Education and Research Cost Advisory Committee (MERCAC), and will request that MERCAC annually report to the MMA HOD.

Res. 202, Uniform Credentialing Process

Adopted as amended.

The MMA will convene a task force of appropriate stakeholders to develop a statewide uniform credentialing process and to recommend whether to link the process with the American Medical Accreditation Program (AMAP).

Res. 203, Physician Prescription/Formulary Restrictions

Referred as amended to the Board of Trustees, to take action within three months and to report back to the 1998 House of Delegates.

Resolves that the MMA convene a task force to conduct an in-depth study of health organizations' financial incentives or disincentives to physicians to direct the use or nonuse of a particular medicine or treatment, and that based on the finding of the task force, the MMA develop

Resolutions continued on page 38

Resolutions *continued from page 37*

appropriate policy statements concerning these issues.

Res. 204, Clinical Information Systems

Not adopted.

Resolved that the MMA seek approval from appropriate state and federal legislative bodies for a program offering financial incentives to acquire and develop individual technologic solutions leading to a less expensive, higher quality, and better coordinated global clinical information infrastructure for the state. It further resolved that a preliminary report of recommendations for such a program be available to the MMA membership by January 15, 1998.

Res. 205, Raise the Legal Age for Use of Tobacco Products

Adopted as amended.

See page 33.

Res. 206, Immunization Registry

Adopted as amended.

The MMA will make passage of the immunization registry authorization legislation a priority, and will educate members regarding the benefits, potential risks, and patient confidentiality concerns of an immunization registry.

Res. 207, Legislation Providing for Health Plan Liability

Referred to the Board of Trustees.

See page 34.

Res. 208, Impaired Drivers

Adopted as amended.

See page 33.

Res. 300, Acute Mental Illness

Adopted.

The MMA will work with the Minnesota Department of Human Services to accomplish rule changes that reflect the reality of treating acute mental illness in the rural setting, and thus, allow appropriate inpatient treatment for such patients when an outpatient alternative is not available. If attempts to work with the DHS in rule revision are unsuccessful, the MMA will pursue legislation requiring such changes.

Res. 301, Motorcycle Safety

Adopted as amended.

The MMA will work with the state departments of Transportation and Public Safety to identify options for improving motorcycle safety. Also, the Minnesota delegation to the AMA will ask the AMA to work with national organizations in pursuit of the same goal.

Res. 302, Birth Defects Information System

Adopted as amended.

The MMA will support the implementation of a Birth Defects Information System at the legislative level, recognizing the overwhelming importance of strict patient confidentiality and the need for research and monitoring of the birth defects occurring within the state.

Res. 303, Seat Belt Safety

Adopted as amended.

The MMA reaffirms existing MMA policy to develop and pursue legislation that would make nonuse of seat belts a primary offense punishable by a $100 fine. This legislation will be a high priority during the 1998 legislative session, and the MMA will conduct a public education campaign on the benefits of seat belt use.

Res. 304, Protective Headgear

Adopted as amended.

The MMA, in an effort to improve the public's health, will continue to pursue legislation specifying that the nonuse of helmets for bicycles, motorcycles, snowmobiles, and ATVs is a petty misdemeanor punishable by a $25 fine.

Res. 305, Personal Flotation Devices

Adopted as amended.

The MMA reaffirms existing policy to support legislation that mandates the use of life jackets or flotation devices in Minnesota for children under age 18 while occupying boats and other watercraft in navigable waters.

Res. 306, CPT Code

Not adopted.

Resolved that the MMA recommend to the AMA CPT Editorial Board that a separate CPT code for medical and surgical encounters performed by physician assistants and nurse practitioners be developed.

Res. 307, Tobacco Control Settlement

Adopted as amended.

See tobacco control article on page 34.

Res. 308, Eliminating Delayed Payments to Physicians by Third-Party Payers

Adopted as amended.

See page 34.

Res. 309, Physician Contract Education Program

Adopted as amended.

The MMA will seek to work with the MMGMA and other interested stakeholders to develop an educational program for physicians that addresses common elements found in physician contracts. The MMA, with the AMA, will develop state standards for fair managed care/physician contracts, thereby requiring full disclosure in plain English of important information. The MMA also will assess the feasibility of developing a program to alert members on issues of importance in their contract negotiations.

Res. 310, The Erosion of Medical Decision-Making by Physicians

Adopted as amended.

See page 34.

Res. 311, Stroke Awareness

Adopted as amended.

The MMA endorses coalition efforts to develop public and provider education programs with the goals of increasing the number of patients presenting for care early and extending the rapid medical response to stroke throughout the state. The MMA

encourages the Health Technology Advisory Committee (HTAC) to plan and implement strategies for promoting effective management of ischemic stroke. Finally, the MMA will recommend that the AMA study early intervention for ischemic strokes.

Res. 312, Anti-Microbial Prescribing Practices

Adopted as amended.

The MMA will assist physicians in improving patient and community awareness of the need for appropriate anti-microbial prescribing practices. Accordingly, the MMA will form a task force of appropriate professional associations to develop an education and communication plan for the MMA Board of Trustees' consideration within one year from the date of the resolution's adoption, with implementation to begin thereafter.

Res. 313, Center for Emerging Infectious Diseases

Referred to the Board of Trustees.

Resolves that the MMA support the notion of a soundly designed Center for Emerging Infectious Diseases, and work with representatives of the Minnesota Department of Health's Acute Disease Epidemiology Division to plan and design such a center.

Res. 314, Minnesota Health Care Coalition on Violence

Adopted as amended.

The MMA supports the efforts of, and will continue to monitor the work of, the Minnesota Healthcare Coalition on Violence and its task forces. The MMA will provide assistance in promoting of the Minnesota Healthcare Coalition on Violence's statewide educational programs for health care professionals.

Res. 315, Personality Disorders and Disability Act

Referred to the Board of Trustees.

Resolves that the MMA Board of Trustees study and develop a position paper on whether personality disorders constitute "disability" under the Americans with Disabilities Act.

Res. 316, Appropriate Pricing of Health Plan Products

Adopted as amended.

The MMA will urge health care systems to avoid pricing strategies that result in pricing their products in order to achieve larger market share to such an extent that they are later forced to reduce services, cut benefits, or limit access to care for their enrollees. The MMA believes that whenever health plans determine that costs must be cut, direct patient care costs should be the last to be cut. The MMA will convene a forum of health plan representatives, state regulators, and physicians to facilitate communication on the relationship between quality care, cost containment, and product pricing.

Res. 317, Violence Prevention Training Programs

Adopted as amended.

The MMA supports and will participate in the development of violence prevention training programs that include primary and secondary prevention components.

Res. 318, No Compete Clauses

Not adopted.

Resolved that the MMA educate physicians about the possible damaging effects that "no compete clauses" may have on their practices and on their patients, and about ways to effectively negotiate contracts with health care organizations that minimize any such damaging effects. It further resolved that the MMA—through existing and future communication mechanisms—continue to discuss with health plan leadership concerns regarding potential impact of "no compete clauses" on physicians' practices and on their patients.

Res. 319, Cigars and Smokeless Tobacco

Adopted as amended.

See page 33.

Res. 320, Youth Access to Alcohol

Adopted.

The MMA will support efforts to reduce youth access to alcohol by supporting policies that would mandate compliance checks to identify establishments that sell alcohol to underage youth, improve social host laws to hold adults more accountable for supplying alcohol to youth, and maintain local control of alcohol regulatory ordinances.

Res. 321, Passive Smoking

Adopted as amended.

See page 33.

Res. 322, HIV Infection

Adopted as amended.

The MMA supports a standard of medical practice that would approach HIV infection like reportable sexually transmitted diseases, and will work with the Minnesota Department of Health to educate physicians and physicians-in-training regarding effective communication of the importance of HIV testing of pregnant women.

Res. 323, Reimbursement Incentives

Adopted as amended.

See page 34.

Res. 324, Minnesota Physician-Patient Alliance

Referred to the Board of Trustees.

The MMA endorses the efforts of the Minnesota Physician-Patient Alliance (MPPA) to restore control in health care to doctors and patients; will encourage Minnesota physicians to support and join the MPPA; will work with the MPPA to address these issues with HMOs, employers, the media, and the Legislature; and will explore means to use its financial resources in these efforts.

Res. 400, Nursing Home Nurses Caring for Patients in Adjacent Facilities

Referred to the Board of Trustees.

Resolves that the MMA support legislation or rulemaking by the Minnesota Department of Health that would allow nursing home staff to offer care to residents of senior nursing facilities adjacent to nursing homes without further regulation or license requirements by the apartment facil-

Resolutions continued on page 40

Resolutions *continued from page 39*

ity, beyond that already required for care delivery in a nursing home.

Res. 402, Emergency Financial Assistance Near/At End of Life

Not adopted.

Resolved that the MMA join with the Minnesota Hospice Organization to recommend that the state of Minnesota explore the provision of emergency relief assistance to licensed hospice programs in the event of a catastrophic depletion of funds.

Res. 403, Physician Education Re: Pain Control

Not adopted.

Resolved that the MMA sponsor a statewide initiative for physician education on pain management in terminal care.

Res. 404, "Mandate" for End-of-Life Emotional/Spiritual Support

Not adopted.

Resolved that the MMA recommend establishment of community-based consortiums designed to improve the quality of palliative care for people who are dying.

Res. 405, Use of Advance Directives

Adopted as amended.

The MMA will continue its collaboration with the Minnesota Bar Association in the development of easy-to-complete advance directives. The MMA also will work with other professional and state health agencies, including the Minnesota Department of Health, to develop strategies utilizing local organizations (e.g., senior centers and religious organizations) to disseminate information regarding the purpose and use of advance directives.

Res. 406, Palliative Medicine Education

Adopted as amended.

The MMA will recommend that undergraduate, graduate, and continuing medical education for appropriate physicians in Minnesota include a formal palliative care component.

Res. 407, Protect Prescriber from Fraudulent Use of DEA Number

Adopted.

The MMA will work with the AMA to introduce state and federal legislation to outlaw the practice of requiring Drug Enforcement Agency (DEA) numbers for noncontrolled substance prescriptions, and outlaw the sale or release of DEA number data to nongovernmental entities, and outlaw the use of DEA number data to track prescription histories of physicians for commercial use.

Res. 408, Antitrust Laws and Physician Negotiation with Health Plans

Adopted as amended.

See page 34.

Res. 409, Out-of-Hospital Do-Not-Resuscitate Orders

Adopted as amended.

The MMA reaffirms its Emergency Care Guidelines for Resuscitation and will work with other appropriate agencies to develop strategies for effective dissemination of the document to the members and to the public.

Res. 410, Task Force on Metropolitan Hospital Bed Capacity

Adopted as amended.

The MMA will appoint a Task Force on Metropolitan Hospital Bed Capacity to include representatives designated by the Ramsey Medical Society, the Hennepin Medical Society, hospital and health care corporations, hospital boards, and community representatives. The task force will report to the MMA Board of Trustees on all aspects of hospital bed capacity in the metropolitan Twin Cities, and make recommendations for solutions.

Res. 411, Reporting by the Media

Adopted.

The MMA Board of Trustees will study and recommend appropriate strategies to work with the media to provide more responsible health reporting by offering the availability of physician expertise to review/respond to heath information prior to its airing.

Res. 412, Nondiscrimination in Physician Licensure

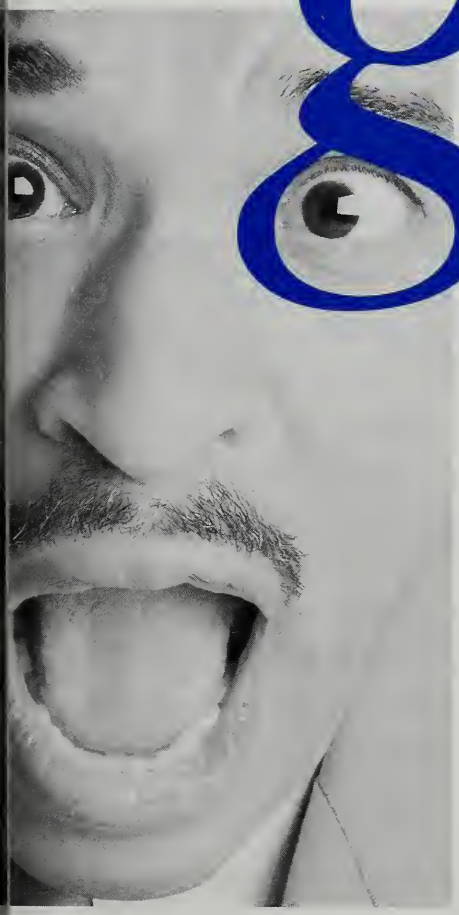
Adopted as amended.

The MMA will urge the Board of Medical Practice (BMP) to deal respectfully and fairly with applicants for licensure and licensees, ensuring that individual rights to be free from discriminatory practices are not violated. The MMA will continue to closely monitor the investigations being conducted by state and federal agencies as to whether the questions asked by the BMP related to psychological or emotional disorders or conditions, and the consequent investigatory process following an affirmative response, violate state and federal antidiscrimination laws. The MMA will report the results of the monitoring to the MMA HOD in 1998, and convey its concerns regarding this matter directly to the BMP. • • • • •

The Monitor
OCTOBER 1997
• • •
PRESIDENT
Kent S. Wilson, M.D.
CHAIR, BOARD OF TRUSTEES
Paul C. Matson, M.D.
CHIEF EXECUTIVE OFFICER
Paul S. Sanders, M.D.
EDITOR
Lorrie Holmgren
WRITER
Susan Maas
• • •

OFFICE PRODUCTS AT PRICES THAT WILL MAKE YOU *gasp*

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED



We all need office supplies. The key is to find the vendor that carries everything you need at the best possible prices. MMBR has selected Office Depot as our endorsed office supply vendor. Through MMBR, you can save an average of *40 percent off* all general office supplies and furniture. MMBR has also arranged retail store pricing on *electronics, business machines, and software,* a special *Purchasing Card* to take advantage of volume discounts at 7 Twin Cities retail stores, and additional *frequent buyer discounts.* Ask about our *convenient billing options.* MMBR can put the immediate response of *Internet* and specialized software ordering at your fingertips, and *next day delivery* is standard with nearly all products. For personal attention and unparalleled service, call 623-2860, or toll free 800-298-MMBR (6627), and ask for our office supply program.

MMBR

OFFICE SUPPLY

MINNESOTA MEDICAL BUSINESS RESOURCES
OWNED BY MMA & HMS

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.

3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Screening for Domestic Violence in a Rural Family Practice

Deane Johnson, M.D., and Barbara Elliott, Ph.D.

ABSTRACT

This study evaluates the effectiveness of a screening form used to assess the incidence of current and post domestic abuse among patients seen in a rural family practice. Two of nine family physicians screened most adult women they saw at a rural primary care clinic for three months in early 1996. Of the 280 women who completed surveys, 94 (34%) reported experiencing physical or emotional abuse at some time in the post. Twenty-three (8%) reparted physical abuse within the past year. Fourteen women (5%) reported being currently afraid of their partner or someone else. Although current or past abuse was seen across all groups, women reporting abuse were more likely to be unmarried, younger, and on medical assistance. They were also more likely to have children at home. We concluded that the prevalence of women reporting current abuse in a rural family practice is sufficient to warrant mass screening.

Domestic violence is limited neither to urban families nor to a particular racial or socioeconomic group. An estimated 2 million women are assaulted by their partners each year in the United States, and more than one quarter of all women in the United States will be abused by a partner at some time in their lives.[1] A study in Georgia showed a similar experience of abuse among black, white, rural, and urban women.[2] An in-depth survey of patients at a community family practice residency clinic in Duluth in 1993 found that 12% of women reported being currently involved in an abusive relationship.[3] Because women usually do not raise the subject on their own, and the medical and psychiatric sequelae of abuse are significant and sometimes life-threatening, some form of mass screening for domestic violence is warranted. At least one study demonstrated that patients are more likely to provide information about abuse when providers give permission by wearing a button that says, "It's OK to talk to me about family violence and abuse."[4] Other screening options could include a written questionnaire or verbal questions from either a provider or ancillary staff.

This article reports the findings of a project to determine whether screening for domestic violence is feasible in a rural private practice. To be effective in a busy practice, screening must be efficient yet still identify as many affected patients as possible. We chose to try a brief questionnaire that the patient could complete while waiting for the doctor to enter the exam room.

Methods

We developed a five-item questionnaire that patients could complete by themselves (see the figure on page 44). The screening questions were adapted from the American Medical Association Diagnostic and Treatment Guidelines on Domestic Violence as well as from other guidelines.[1,5,6] Two (both men) of nine family physicians at the central clinic of our rural practice screened all women over age 18 for a period of three months. Women who were physically or mentally unable to complete the questionnaire and some who refused to participate were not screened. In addition, a small number of patients were missed due to oversight.

The nurse who brought the patient to the exam room first recorded the patient's age, race, insurance status, relationship status, employment, whether the patient had children at home, and type of visit (scheduled, physical exam, or acute care). The patient was asked to complete the abuse assessment form after the nurse left the room. When the doctor entered, he briefly reviewed the document. If the patient's responses indicated no history of partner violence, the physician asked if she had any questions; if not, he proceeded with the visit as usual. If the patient reported experience with domestic violence, the issue was explored to the extent she was willing to talk at the time. After the office visit, the screening form was filed separately from the patient's chart but was coded with the chart number for future reference. A stamp on the chart indicated the screening date and whether or not a history of abuse was reported.

Results

In total, 280 surveys were completed. The table (page 45) summarizes the characteristics of the sample group. Respondents were predominantly white (95%) and ranged in age from

CONFIDENTIAL ABUSE ASSESSMENT SCREEN

(To be completed by patient)

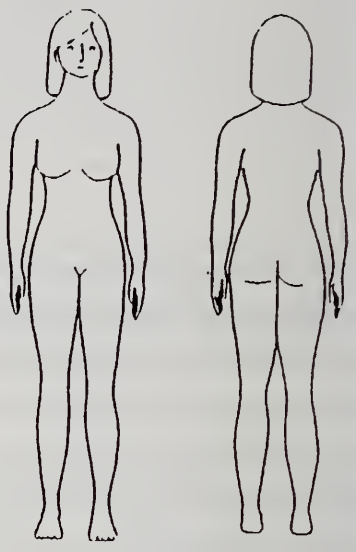
1. Have you ever been emotionally or physically abused by your partner or someone important to you?

Yes _____ No _____ Describe briefly _____

2. Within the last year, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

Yes _____ No _____
If yes, by whom? _____
Number of times _____

Mark the area of injury on the body map



3. During pregnancy, have you been hit, slapped, kicked, or otherwise physically hurt by someone?

Yes _____ No _____
If yes, by whom? _____
Number of times _____

4. Within the last year, has anyone forced you to have sexual activities?

If yes, who? _____
Number of times _____

5. Are you afraid of your partner or anyone you listed above?

Yes _____ No _____

Developed by the Nursing Research Consortium on Violence and Abuse. 1989. Reprinted from MCN Vol. 16, p. 162, May-June 1991.

18 to 94. A majority, 52%, were married, and 35% had children at home. (The 12 women who refused to complete the questionnaire resembled those who did with one exception: a higher percentage of the 12 either were or had been married.)

To the first question, "Have you ever been emotionally or physically abused by your partner or someone important to you?" 94 women (34%) checked "Yes." Of those reporting abuse, 39 (41%) specified physical abuse and 6 (6%) sexual abuse. The abuser was most often a husband, ex-husband, boyfriend, or ex-boyfriend.

Twenty-three (8%) of the 280 women reported that they had been physically abused in the past year. The usual perpetrators were husbands, ex-husbands, boyfriends, and ex-boyfriends. Twenty-six (9%) reported abuse during a pregnancy; their abusers were also in these categories. Fourteen women (5%) reported being currently afraid of their partners or someone else.

While the abused women tended to have certain characteristics in common, abuse, current or past, was seen across all groups. The analysis, summarized in the table, shows that those who reported abuse were younger ($p<0.0001$) and more likely to have children at home ($p<0.005$). They were also more likely to be unmarried (divorced, single, or living with a partner) and on medical assistance than those not reporting abuse ($p<0.0001$). Widowed women were least likely to report abuse. There was no significant difference in the employment status or type of office visit among women reporting violence compared with those who reported no abuse.

Discussion

The results show that domestic violence is prevalent in a rural, predominantly white family practice. The overall prevalence for abuse we found is somewhat lower than that reported in other studies. This could be because the incidence of abuse is lower in this geographic area or because the sensitivity level of this screening form is lower compared with the personal interviews used in some studies.[1-3]

Among the women reporting abuse in this study, a high proportion were younger, unmarried, on medical assistance, and had children at home. Whether this is significant enough to limit screening to certain populations is debatable, but it does identify a higher-risk group within this particular practice. This finding may not be applicable to practices with different demographics.

The screening form and procedure were generally well-accepted in our clinic. Women who reported past abuse expressed appreciation that the questions were raised. Office staff spent two to five minutes processing each form, but that time would decrease after a patient's first screening.

A previous study showed that many physicians resist asking about domestic violence because of their lack of comfort, fear of offending patients, perceived loss of control, and time constraints.[7] Physician time spent on this project was usually less than one minute per screen, except for those screens that revealed ongoing, current abuse (8%). Physicians spent more time talking in depth with these patients, assessing the extent of the violence and discussing appropriate community resources. The physicians judged the additional time as worthwhile. Studies have shown that the reason for patients'

clinic visits often relates directly or indirectly to abuse; early identification of abuse as the underlying problem leads to more effective care and may be lifesaving. Identifying and addressing the abuse can help reduce children's exposure to violence in the home; two-thirds of the women who reported abuse in the past year had children at home.

Conclusion

Generally accepted criteria for implementing any screening program are 1) the problem being investigated affects significant numbers of patients; 2) the problem results in significant morbidity or mortality that can be reduced with treatment; and 3) the screening procedure is feasible and cost-effective.

The 8% incidence of reported physical abuse within the past year discovered in this study is certainly sufficient to warrant a screening procedure in our practice. One emergency department study showed that before the introduction of a screening protocol, 6% of trauma patients were identified as abuse victims, whereas 30% were subsequently identified with routine screening.[8]

The screening form and procedure used at our clinic proved effective, although verbal questioning may have been more sensitive in identifying current abuse. Questions regarding current abuse should be incorporated into standard history questionnaires for all female patients. Teens who have begun dating, and especially all pregnant women, should have these discussions. In our opinion, the most important questions to identify current abuse are whether a woman has "ever been hit, kicked, slapped, or otherwise hurt" by her partner and if she has "ever been afraid that might happen."

Physicians and other health care providers can become more comfortable identifying and dealing with reported abuse by learning more about how to handle these situations safely and effectively. The American Medical Association has extensive literature and a series of booklets describing diagnostic and treatment guidelines for all types of family violence, including domestic violence. For details, call the AMA National Medical Resource Center, 312/464-5066, or fax 312/464-5841. (See also the MMA Diagnostic and Treatment Guide to Domestic Violence, pages 21-22.) Battered women's services, available in most areas, are willing to help providers with referrals and information about dealing with abuse, and they can give invaluable assistance in individual cases. MM

Table

Characteristics of women in the study (N=280)

	Never abused N=186	Abused N=94	Abused last year N=23	Abused in past N=72
Average age (years)*	54	44	39	45
Relationship status*				
Percentage married	59	45	33	47
Percentage live-in	3	6	14	4
Percentage divorced/single	24	48	53	47
Percentage with children at home†	30	48	67	43
Percentage with Medicaid†	15	44	65	37
Percentage employed	53	58	40	62

*p<0.0001
† p<0.005

Acknowledgment

This project was supported by Dakota Clinic-Park Rapids and Battered Women's Services of Hubbard County, Inc. Thank you to Flo Hedeen, Carter Hedeen, D.O., Patricia Davis, Loretta Nilson, and Diane Saar for their time and effort in planning and implementing the program and to Kate Beattie for her computer and statistical work.

Deane Johnson is a family physician at Dakota Clinic–Park Rapids and a clinical associate professor, Department of Family Medicine, University of Minnesota. Barbara Elliott is an associate professor in the departments of Family Medicine and Behavioral Sciences at the University of Minnesota-Duluth.

References

1. American Medical Association diagnostic and treatment guidelines on domestic violence. Arch Fam Med 1992;1:115-23.
2. Wagner PJ, Mongan P, Hamrick D, Hendrick LK. Experience of abuse in primary care patients: racial and rural differences. Arch Fam Med 1995;4:956-61.
3. Elliott BA, Johnson MMP. Domestic violence in a primary care setting: patterns and prevalence. Arch Fam Med 1995;4:113-9.
4. Bolin L, Elliott B. Physician detection of family violence. Minn Med 1996;79(6):42-5.
5. Parker B, McFarlane J. Identifying and helping battered pregnant women. MCN Am J Matern Child Nurs 1991;16:161-4.
6. Hoff LA, Rosenbaum L. A victimization assessment tool: instrument development and clinical implications. Adv Nurs 1994;20:627-34.
7. Sugg NK, Inui T. Primary care physicians' response to domestic violence. JAMA 1992;267:3157-60.
8. McLeer SV, Anwar R. The role of the emergency physician in the prevention of domestic violence. Ann Emerg Med 1987;16:1155-61.

Urgent Care



An ***exceptional opportunity*** exists for Urgent Care physicians to practice in the Duluth/Superior area in four clinics within the expanding St. Luke's system. Excellent compensation and benefit package accompanies state-of-the-art facilities.

St. Luke's is a JCAHO accredited, not-for-profit, non-denominational hospital and Level II Regional Trauma Center serving a population of 440,000 people.

Located on the shores of Lake Superior, Duluth is a thriving city within miles of the beautiful northwoods. The area boasts three universities (one with a medical school), cultural centers including symphony, ballet, and theater, four season recreation activities and is the regional medical center for portions of Minnesota, Wisconsin, Michigan and Ontario, Canada.

St. Luke's
Hospital & Regional Trauma Center

Contact Bob Preston
(800) 894-5131
(218) 728-1565 FAX

Affiliated
COMMUNITY
Medical Centers, P.A.

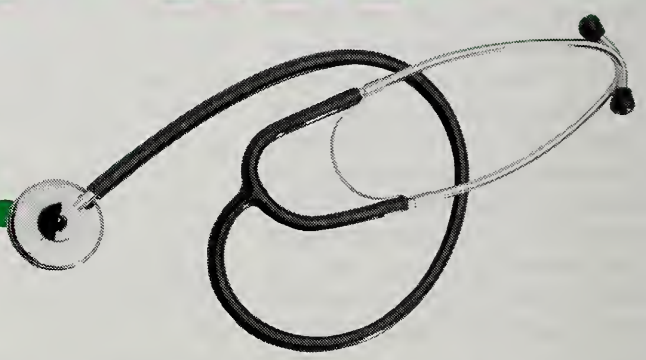
Join the security of a large multispecialty group located in Southwest and West Central Minnesota Communities of 3,700 to 19,000. All areas flourish with four-season recreational opportunities, strong economies and excellent education where family and lifestyle are a priority. Outstanding benefits for BE/BC physicians in:

Dermatology	Neurology
Family Practice	Ob-Gyn
Internal Medicine	Orthopedic Surgery

Contact: Janiece Durham
Physician Recruitment Coordinator
Affiliated Community Medical Centers
101 Willmar Avenue SW
Willmar, Minnesota 56201-3591
320-231-6366

www.startribune.com/workavenue

MAKE YOUR ROUNDS ON NEW GROUNDS.





Put your resume on WorkAvenue.com. It's a free, Star Tribune Internet Web site that automatically matches job openings with resumes from people in the health field and other industries. It's free, easy and confidential.* So go to the site. Because we make finding a new job painless.

If you don't have Internet access, send your resume to WorkAvenue.com, Star Tribune, P.O. Box 1617, Mpls., MN 55440-1617. It'll be electronically scanned and placed in the Workavenue.com database. For best results, call 612-673-9012 first.

*The confidentiality feature is only available when you enter your resume on-line.

www.startribune.com/workavenue

Star Tribune
It's where you live.

370073R/7/97

Legal Issues and Remedies for Victims of Domestic Violence

Although physicians may be tempted to report domestic abuse to authorities, in most cases, they can better serve patients by providing compassion, basic legal information, and referral.

Loretta M. Frederick, J.D., and Andrea C. Farney, J.D.

Domestic violence is a private crime, secreted by society for centuries, despite its prevalence. Often, a physician may be the only person a battered women turns to for help. Concerned that the patient is a victim of terrorism in her own home, the physician may be tempted to call the police to report the crime. This may not be best for the victim, however, and in most cases is prohibited by law. A physician who responds with knowledge and sensitivity can better aid the abused patient.

An informed physician will provide the best possible health care, offer basic information about services and legal remedies, and document the abuse and its effects.

Documentation is critical. Although Minnesota remains a national leader in the movement to provide legal protections for victims of domestic abuse, such protections are only available to those who can demonstrate that the abuse has occurred. Documentation of abuse often means the difference between success and failure in a battered woman's attempts to escape the abuse and to protect her children from its dangers.

Reporting Criminal or Other Abuse

Because acts of domestic abuse constitute criminal behavior, physicians must know whether they have either the right or the responsibility to report the crime. The answer depends on the patient's health, ability or disability, and other characteristics. However, in all but a few cases, battered women are legally competent adults who have the right to confidentiality in the physician-patient relationship. Generally, only the patient can waive this right; in the absence of such a waiver, reporting violates the patient's rights.

The patient's right to confidentiality extends to situations in which the physician or medical records are subpoenaed. Minnesota law establishes a testimonial privilege that prevents the physician (or other health care professional) from divulging, even in court, without the patient's permission any information or opinion that he or she acquired while treating the patient. However, if a third person other than medical personnel (including social workers) is present in the exam room with the patient's permission, the privilege does not exist and the patient cannot prevent the physician from disclosing information to the court.

Although rare exceptions to the rule exist (such as abuse of a child or a vulnerable adult), patients have a right to confidentiality.

Mandated reporting

In certain situations, other state laws compel physicians to report certain kinds of injuries or abuse. Minnesota law requires health care professionals to report all bullet wounds and other injuries from the discharge of firearms, any traumatic brain or spinal cord injuries, and severe burns.

Health care providers must also report abuse or neglect of children or vulnerable adults. Since approximately 50 percent of adults who batter their partners also batter their children, the statutory child maltreatment reporting requirements may also come into play in domestic abuse cases. Such laws require reports of suspected physical abuse, sexual abuse, or neglect of a minor child. An oral report must be followed by a written report within 72 hours, exclusive of weekends and holidays.

A vulnerable adult in Minnesota is a person who 1) lives in or receives services from a facility licensed by the Minnesota Department of Health (e.g., nursing homes or hospitals) or the Department of Human Services (e.g., chemical dependency treatment programs) or 2) regardless of place of residence is unable to or unlikely to report abuse or neglect without assistance because of impairment of a physical or mental function or emotional status. A battered woman who is also a vulnerable adult does not have the legal right to confidentiality; the health care provider is obliged by law to report abuse and neglect of such vulnerable adults. Failure to comply with this reporting requirement can result in civil liability and, theoretically, in criminal charges against the health care professional.

When physicians must determine whether a patient is a vulnerable adult, they should consider whether the victim's failure to report the abuse is due to "impairment of a physical

or mental function or emotional status." Being battered does not make an otherwise competent and normal adult a vulnerable adult. Battered women commonly decline to report their own abuse to authorities out of fear, often well-founded. Reporting the crime will not necessarily increase the victim's safety. In fact, the abuser may retaliate against the woman by beating her or by preventing her from seeking medical attention in the future. And even if the criminal justice system intervenes, the victim's safety is not always a key concern in the criminal procedure.

Recently, the American Medical Association joined the American Bar Association in a national effort to create a coordinated community response to domestic violence that, among other things, would improve the criminal justice system's response to domestic violence.

Whether or not reporting is required by law, physicians can respond to a victim of battering with compassion and understanding. They can provide information about remedies and options, including referrals to domestic violence programs, and give clear and supportive messages.

Documenting Abuse and Injuries

Physicians are in a unique position to document the injuries a violent partner inflicts (see related article on E-coding, page 28). Such documentation has many uses. The Order for Protection, which is a civil court order that tells the abuser to stop abusing or threatening the victim and can ban the abuser from entering the home, is available only to people who can prove by a preponderance of evidence that they are victims of domestic abuse. The outcome of child custody cases can hinge on whether the court believes one of the parents abused the other and that the children were affected by the abuse.

When a couple divorces, many court procedures are altered if evidence of domestic abuse exists. For example, a battered woman will not be compelled to participate in mediation (face-to-face negotiation sessions over the disputed issues) with her abuser before a judge will hear her case. And if the parties are ordered to attend a series of educational classes on divorce and the effect on children, she will not be forced to attend the same session as her abuser. If she is an immigrant woman married to a citizen or legal resident of the United States and she can show that she is being battered, she is permitted by new federal laws to petition for her own residency instead of being forced to stay with her husband, who otherwise has exclusive power to petition for her residency. And most significantly, under recent welfare reform provisions, demonstrating that she is abused may be the only way she can become eligible for the emergency government benefits that will allow her and her children to survive on their own.

The outcome of a criminal case against the abuser can hinge on photographs and other documentation of injury, and getting a conviction may be the only way to hold the violent person accountable and order him to attend a batterers' treatment program.

Legal Remedies

Criminal proceedings

In Minnesota, it is a crime to assault or threaten someone, and the penalties for doing so are heavier in domestic violence cases with each succeeding conviction. Increasingly in Minnesota, prosecutors are taking these cases seriously and may prosecute the offender even when the victim is not interested in doing so. When the defendant pleads not guilty and is brought to trial, the state must prove that the act was committed "beyond a reasonable doubt" in the mind of the judge or jury member. The court that convicts an abuser can order the batterer into a treatment program on condition of probation and can also sentence the offender to jail.

Order for Protection

Since it took effect in 1979, the Order for Protection (OFP) has become the most widely used and significant remedy available to Minnesota's victims of domestic violence. The OFP, a court order that restrains an abuser from committing further abuse, can also ban the abuser from living in his or her own home or coming within a certain distance of the petitioner's residence.

An OFP is available to any person who is a victim of domestic abuse, which is legally defined as physical harm, bodily injury, assault, terroristic threats, sexual assault, or the infliction of fear of imminent physical harm, bodily injury, or assault. The domestic abuse must have occurred between family or household members, defined as spouses, former spouses, parents and their children, people related by blood, people who either currently live together or have done so in the past, people who have a child in common (including a pregnant woman and the abusive man alleged to be the child's father), and people involved in a significant romantic or sexual relationship.

The OFP is available to women or men battered in heterosexual or homosexual relationships, as well as to roommates and family members. Dating couples are also covered as long as the judge finds that they have had a significant romantic or sexual relationship, which is determined by the type and length of the relationship, the frequency of interaction between the parties, and, if the relationship has ended, the length of time since the breakup. An OFP may be obtained on behalf of a minor by the minor's parent, a legal guardian, or an adult age 25 or older. In certain cases, minors age 16 or older may apply for OFPs on their own.

The procedure for obtaining an OFP is relatively simple. The victim goes to the court administrator's office at the local county courthouse for forms and assistance, which that office must provide to anyone who asks. The victim does not need an attorney to assist in either the application or the court hearing. The customary court-filing fee and cost of service are waived in OFP proceedings.

In most counties, the court administrator presents the completed OFP application to the judge for consideration. If the petition alleges an immediate and present danger of domestic abuse, the court may issue

an immediate order to restrain the abuser from committing acts of abuse, ban the abuser from the petitioner's residence (even if shared with the victim), ban the abuser from the petitioner's place of employment, and continue the victim's current health insurance coverage without change in the level of coverage or beneficiary designation (critical for patients who have ongoing health problems). The alleged abuser is personally notified, usually by local sheriff's deputies, who will also ensure that the abuser leaves the home if so ordered. Sometimes the victim does not know where the abuser is or the abuser hides. An OFP is still possible to obtain through special notification rules.

In most cases, a court hearing is held within 14 days after the first order or after the application date, except when neither party requests a hearing and no children are affected.

At the hearing, the judge or referee may expect the parties, at least the petitioner, to testify about the abuse. If the court finds that abuse has occurred, it will issue an order, which usually is in effect for one year. The order can do the following:

- restrain the abuser from committing domestic abuse;
- ban the abuser from the victim's residence or place of employment;
- award temporary child custody and visitation rights;
- establish temporary child and/or spousal support;
- order treatment for the abuser or counseling for both parties if they have children and the victim requests it;
- order the abuser to pay restitution to the victim;
- award temporary use of personal property, such as cars; and
- continue all currently available health insurance coverage for the abused individual without change.

Dissolution of marriage

Divorce, called "dissolution of marriage" in Minnesota, is another legal remedy available to women who are abused by their husbands. In a divorce proceeding, the court can issue restraining orders as in an Order for Protection. There is, however, no legal requirement that police arrest an abuser who violates a divorce restraining order, so the battered woman might want to obtain an Order for Protection in addition to the regular divorce court orders.

The dissolution of marriage can only be used if at least one spouse has been a resident of Minnesota for at least 180 days. The dissolution court can make permanent property distribution orders, as well as child or spousal support, child custody, and visitation orders.

Threats to hurt, kill, kidnap, or win custody of children are among the most common and effective means batterers use to keep their partners from leaving them. Because partners' mental and physical health is one factor in courts' child-custody decisions, and because battered women often suffer from situational but severe anxiety and/or depression as a result of abuse, it is imperative that physicians avoid making diagnoses, particularly of mental health problems, that do not clearly reflect the impact of abuse on the victim's con-

First Call Physicians, Inc.
A Locum Tenens Service
500 Eighth Ave. S.
Buffalo, MN 55313

Clinics/Hospital | **Physicians**

Locums Coverage
=
Revenue

- Patients falling through the gaps?
- Physician burnout or illness?
- Shortage of physicians?

- Earn more with less time.
- No administrative headaches.
- Malpractice premium paid.

Experience, Service, Honesty
Call (metro) 682-3852
(toll free) 888-682-3852

(You'll be glad you did!)

Creative solutions for all your health care legal problems

Members of the Firm's Health Law Group:

Daniel J. McInerney, Jr. 335-1782
David R. Melloh 335-1674
Timothy A. Johnson 335-1789

Law Offices
150 South Fifth Street Suite 2300
Minneapolis, Minnesota 55402
612-335-1500

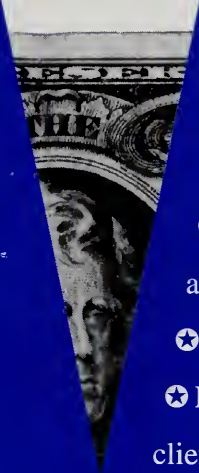
LEONARD STREET AND DEINARD

DID YOU KNOW THAT MMBR'S EMPLOYEE BENEFITS TEAM CAN HELP YOU

BRIDGE THE GAP

Did you know that MMBR, the resource company owned by the Minnesota Medical Association and Hennepin Medical Society, can really help you with the challenges of providing employee benefits?

That's right. Because providing services to medical professionals is our only specialty, you can be sure that MMBR will do a great job in helping you design and obtain quality benefit plans for your practice.



Join the many other medical practices who count on MMBR for employee benefit plans such as:

- ✪ Group medical, dental, disability and life coverage
- ✪ Qualified retirement plans
- ✪ Educational personal finance seminars for your employees
- ✪ Personal financial reviews for physicians and staff
- ✪ Voluntary benefits such as life, disability, and long term care insurance
- ✪ Payroll deduction auto and home insurance
- ✪ Free COBRA administration for MMBR group clients

We work to make bridging the gap convenient and cost effective.

Call Barry Weber or Dan Hagberg today at

800-298-6627

MMBR

Minnesota Medical Business Resources
Owned By MMA & HMS

dition. Many battered women have lost custody of their children to violent fathers, in part because the fathers used inaccurate diagnoses of mental illness to assert that the mother was too mentally unstable to be given custody.

Except in very limited circumstances, an attorney must be retained to file for a divorce. Many battered women have difficulty obtaining legal counsel because they don't have the money or they don't know which local attorneys are sensitive to domestic abuse issues. Physicians should be prepared to provide information about local legal-aid programs and Bar Association referral services. Local battered women's advocacy programs are often a good source for information about attorneys who are experienced at representing battered women (see the Resource Guide, page 22).

CONCLUSION

To help protect patients from ongoing physical and emotional violence, physicians must be knowledgeable about domestic abuse and supplement patient care with a few basic, but critical, services. Such services include providing basic information on domestic violence and on local resources for victims and perpetrators, screening all female patients regardless of the presenting problem, documenting injuries, and showing support and concern. MM

Loretta Frederick is legal counsel for the Criminal Justice Center of the Battered Women's Justice Project in Minneapolis and Winona, Minnesota. She also serves the Domestic Abuse Intervention Project of Duluth and is a consultant for the U.S. Marine Corps on the development of its Coordinated Community Response to domestic violence. Andrea Farney is a former staff attorney with the southeastern Minnesota office of Southern Minnesota Regional Legal Services, Inc., specializing in family and Social Security disability law.

North Central Medical Conference
Presents Exciting Trips From Minneapolis/St. Paul



China - Yangtze River Cruise
Program A - March 27 - April 7, 1998 $2,599
Program B1 - March 21 - April 4, 1998 $3,159
Program B - March 23 - April 6, 1998 $3,099
Per person, double occupancy. (Plus taxes.)
A wonderful introduction to the Orient!



Grand Capitals of Eastern Europe
Germany, Poland and the Czech Republic
April 14-24, 1998 • April 23 - May 3, 1998
May 2-12, 1998 • May 11-21, 1998
$2,145 Per person, double occupancy. (Plus taxes.)
Down came the "Wall" in November 1989. **Berlin** is now brimming with excitement. **Warsaw**, Poland's proud capital and **Krakow** hometown of Pope John Paul II. **Prague**, the "jewel in the crown of the world."



Luxury Alaskan Cruise On Board the mv Mercury
June/July 1998
Details available in December. Northbound or Southbound Glacier Cruise itinerary. Pre-and post-cruise tours available to Denali National Park, Fairbanks, Anchorage and more!

AVAILABLE TO MEMBERS, THEIR FAMILIES AND FRIENDS.
For additional information and a color brochure contact:
GLOBAL HOLIDAYS
9725 Garfield Avenue South, Minneapolis, MN 55420-4240
(612) 948-8322 Toll Free: 1-800-842-9023



Franciscan Skemp Healthcare has a 112-year commitment to providing patient-focused and family-centered care. Now affiliated with Mayo, we continue to provide quality medicine combined with streamlined access to renowned, complex specialty care. We are an integrated delivery network serving a population base of 350,000 and including three hospitals and 12 clinics with 170 active medical providers.



Opportunities are available in: Family Practice Residency Faculty; Emergency Medicine; Hematology/Oncology; ENT; Orthopedics/Sports Medicine; Occupational Medicine; Radiology; Urology; Neonatology; Gastroenterology; and Psychiatry. The practices are available in an ideal, family-oriented environment with outstanding recreational and cultural activities. Excellent public and private schools.

Call Tim Skinner (tskinner@fsh.mayo.edu) or Bonnie Guenther (bguenthe@fsh.mayo.edu) at 800/269-1986. Or visit our website at www.mayo.edu/fsh. ***Not a health manpower shortage area.***

Franciscan Skemp Healthcare
MAYO HEALTH SYSTEM
Your Healthcare Partner with Mayo

Franciscan Skemp Healthcare
700 West Avenue South
La Crosse, WI 54601
608/791-9844
FAX 608/791-9898

A Healthier Future

Southern Minnesota

Seeking quality primary care trained or emergency medicine physician(s) to practice in ***Blue Earth, Fairmont, Owatonna and Worthington.***

- Stellar Emergency Medicine Practice
- Full-time, regular part-time and moonlighting opportunities
- No restrictive covenants
- Fully accredited CME programs
- St. Paul malpractice insurance
- Competitive bonus, benefit and compensation packages.

ACUTE CARE, INC.

Respond to Melissa Milliken, CMSC, CMSR, Director of Development, 515-964-2772, 800-729-7813 or send CV to P.O. Box 515, Ankeny, Iowa 50021.

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142

E-Mail: stephanie.l.jussila@qm.healthpartners.com

Central Minnesota Group Health Plan

HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220

HealthPartners®
Institute for Medical Education

CME

Continuing Medical Education
1997 Winter Conference Schedule

Changing General Surgical Practices	November 13-14
Strategies in Primary Care	November 13-15
Low Back Pain	November 19
Current Challenges to Employee Health: The Health Care Environment, Infection Control Issues, Ergonomics & Workplace Violence	November 20-21
Cardiovascular Conference	December 4-5
Pediatric Orthopaedic Update	December 5
Fitting the Work to the Worker: Preplacement Evaluation, Advanced Medical Case Management	December 11-12

In 1996, the HealthPartners Institute for Medical Education (IME) was created to support the ongoing development of excellence in clinical practice through a wide variety of educational services. The Institute has development, coordination and oversight responsibilities for the undergraduate, graduate and continuing education initiatives for health professionals within the various divisions of HealthPartners including Regions Hospital.

For Further Information Contact:
Institute for Medical Education
Continuing Education
640 Jackson Street • St. Paul, MN 55101
Phone 612-221-3223 • Fax 612-292-4773

People and Places Making Medical News

People

Office of Rural Health Names New Director

Estelle Brouwer was recently named director of the Office of Rural Health and Primary Care at the Minnesota Department of Health. Brouwer, who began her new position in September, was previously a research fellow with the Minnesota Extension Service and the Humphrey Institute of Public Affairs, serving as the director for outreach and extension. A native of Tyler, she served as an assistant to the commissioner of health from 1989 to 1991.

St. Paul Physician Honored with International Citizen Award

Patricia Walker, M.D., an internist with Regions Hospital (formerly St. Paul-Ramsey Medical Center), received a 1997 Twin Cities International Citizens Award, which honors people whose work has contributed significantly to international understanding, cooperation, friendship, and development. The awards were presented at a celebration in Minneapolis on September 24.

Bolles Bolles-Rogers Bowl Awarded to Late Dr. Cassius M.C. Ellis

The late **Cassius M.C. Ellis, M.D.**, was awarded the Charles Bolles Bolles-Rogers Bowl by the Hennepin Medical Society. The award is given annually to a physician deemed outstanding for his or her professional contributions in medical research, achievement, or leadership. Phyllis Ellis, Dr. Ellis's wife, accepted the award at a meeting of the North Memorial Medical Center medical staff on September 9. Cassius Ellis, who died May 15, was North Memorial's director of surgical education. He was also a professor of surgery and assistant dean for minority affairs at the University of Minnesota Medical School.

Ellis was noted for his contributions to medical education. "He was one of our best teachers," said **John Najarian, M.D.**, clinical professor of surgery at the University of Minnesota, in a eulogy at Ellis's funeral (see the September issue of *Minnesota Medicine* for the complete eulogy text). "A rotation on his surgical service was most sought after by our surgical residents and medical students." Ellis was also widely praised for his efforts to increase the number of minority medical students at the University of Minnesota and elsewhere.

Shotwell Award Goes to Carl Platou

Hennepin Medical Society has awarded **Carl Platou** the Shotwell Award for his exemplary service in the health care field. Platou, director of the Center for Health and Medical Affairs at the University of St. Thomas and president emeritus of Fairview, accepted the award September 15 at the Minnesota Medical Association's Annual Meeting in Brainerd, Minnesota.

HMS chose Platou for the award based on his role as a teacher of hospital and business administration at major universities across the nation, including the University of St. Thomas, and for his contribution to the concept of an integrated, multisite, nonprofit health system.

Platou is considered the father of multihospital holding companies, a concept he introduced to enhance service and economic efficiency during his 37-year tenure with Fairview. Under Platou's guidance, Fairview grew from one of the Twin Cities' smallest hospitals into a major health care system.

"Carl is a real visionary. He is responsible for the initial concept of moving hospital care closer to the patient," said **Royce Sanner**, current chair of the Fairview Health System board of directors and an attorney with Maslon Edelman Borman & Brand, LLC. "Carl is a man of great integrity and boundless energy."

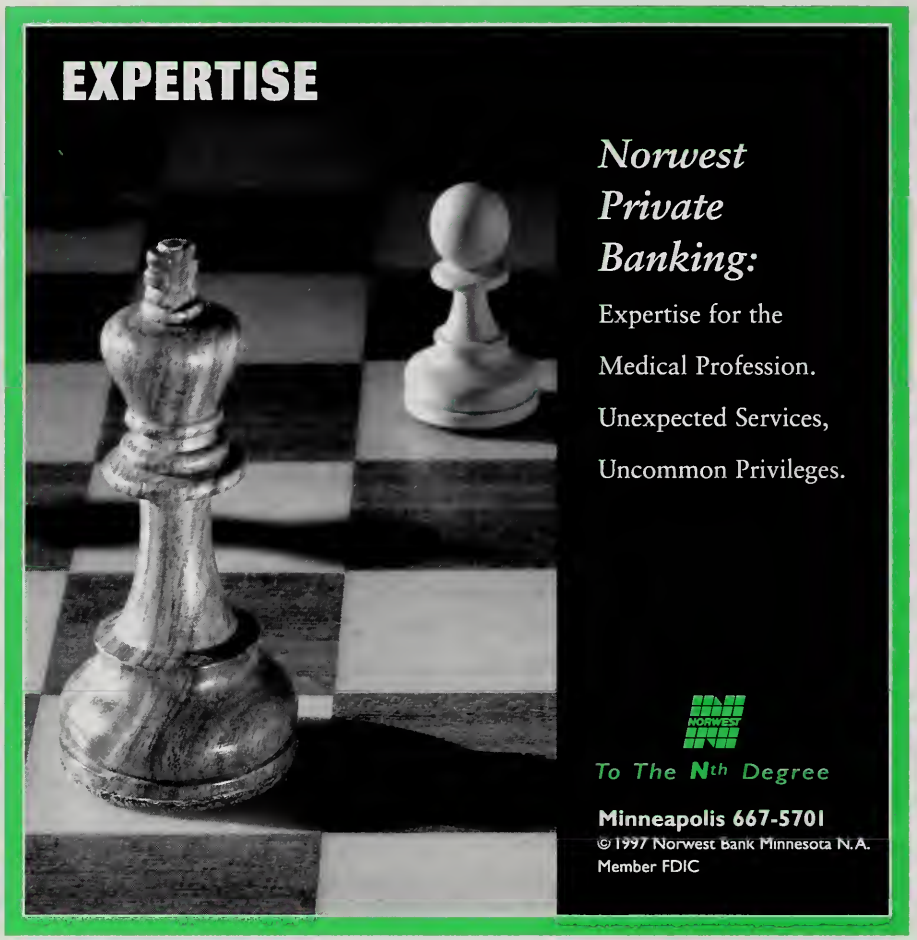
Places

Children's Health Care Plans New Building

Children's Health Care announced it will build a new pediatric professional office building at its Children's-West site in Minnetonka. The building's major tenant will be a new west-metro clinic for Gillette Children's Specialty Healthcare. Other practices, including pediatrics, pediatric ophthalmology, pediatric pulmonology, and pediatric dentistry, will also lease space in the 40,000-square-foot building. Construction on the $3.8 million project is expected to be completed by spring 1998.

Woodbury Health Care Campus Gets Name

The health care campus being planned on a 26.4-acre site in Woodbury has been named Woodwinds Health Campus. Partners in the project are HealthEast, Allina Health System, and Children's Health Care. Construction of the 50,000- to 70,000-square-foot medical office building will begin this fall. The offices, which will house primary and specialty care physicians, are scheduled to open in fall 1998. Construction on the rest of the campus, including a 105-bed acute care hospital and a diagnostic and therapeutic facility, will begin next spring and will be completed in 2000.



Twin Cities Spine Center Formed

Two of the region's spinal surgery practices—Minnesota Spine Center and the Twin Cities Scoliosis Spine Center—have joined to form the Twin Cities Spine Center. The new practice will specialize in the comprehensive management of all spine diseases and disorders of the cervical, thoracic, and lumbar spine. The Twin Cities Spine Center has two Minneapolis locations: 606 24th Avenue South and 2800 Chicago Avenue South.

Socioeconomics

Physicians Rate Health Plans

A majority of Twin Cities physicians admitted that they wouldn't recommend the health plan they work for or contract with to a member of their family who needed care, according to a survey conducted by researchers at the University of Minnesota.

The nearly 1,200 physicians who responded to the survey were participating providers at four of the largest health organizations in the Twin Cities—HealthPartners, Medica, PreferredOne, and Blue Plus.

Physicians at the HealthPartners clinics gave the highest points to their plan. Meanwhile, the lowest scores were given by physicians whose patients are covered by Blue Plus, an HMO owned by Blue Cross and Blue Shield of Minnesota.

The survey, conducted between 1995 and 1997, is the first of its kind that tries to measure quality of care through the eyes of the physician, said its lead authors, Nicole Lurie, M.D., M.S.P.H., and Steven Borwosky, M.D., M.P.H., in an article in the Minneapolis-based *Star Tribune*. The study appeared in the September 1 *Journal of the American Medical Association;* results of a detailed follow-up study were released to the media the same week.

The survey also showed a significant difference among the networks in physician satisfaction and widespread concern about quality of care under managed care plans, especially in areas such as mental health.

Dr. Lurie said she hoped the results would spur dialogue between doctors and health plans. "I hope this will also send a strong message to doctors that you have some obligation to push your plans to change in the areas where they need to improve," she told the *Star Tribune.*

HealthPartners Helps Uganda with Insurance

HealthPartners will help start a health insurance system in Uganda, Africa, using grant money from the U.S. Agency for International Development. HealthPartners is working with Land O'Lakes, which helped several Ugandan communities establish dairy cooperatives, to develop proposals to create health care co-ops that would provide basic preventive care. HealthPartners Chief Executive George Halvorson and other company executives traveled to Uganda for a 10-day site visit in September.

Halvorson said in an interview with the *Star Tribune* that he doesn't expect to transplant many specifics of the American health care delivery system to Uganda. "But what is not different is there are families that want a health care system," he said. Most health care services in Uganda are provided by the government or by missionary organizations. Almost no health insurance is available for Ugandans.

Halvorson and the other HealthPartners representatives planned to meet with leaders of the dairy co-ops, who expressed interest in health care and insurance.

University of Maryland Baltimore

Warning:

Naming yourself or your clinic as trustee of your qualified plan may be hazardous to your health.

If you are a practice manager, plan trustee or have fiduciary responsibilities for a qualified 401(k), profit sharing or pension plan, you will not want to miss this *free informational seminar* opportunity. The seminar is hosted by MMBR and its new trust services partner, Richfield Bank & Trust Co.

SEMINAR: Your Prescription for a Healthy Retirement Plan

Date: Wednesday, November 5, 1997

Time: 8:00 a.m. - 9:30 a.m.

Place: MMA/MMBR Offices
3433 Broadway St. NE, Suite 375
Minneapolis, MN 55413

In the seminar you will learn:

- How to reduce the liability of your clinic and its principals
- What you can do right now to avoid disastrous fiduciary consequences
- Important steps to ensure that your plan is in compliance
- How to set investment policy and monitor fund performance

Potential dangers of serving as a plan fiduciary are great. The liabilities can follow you for your lifetime. We urge you to invest 90 minutes that could save you significant time and money.

PHYSICIAN APPROVED
MMBR
ASSOCIATION ENDORSED

To reserve your space at this seminar, please call MMBR at 800-298-6627.



Is Your Medical Insurance Plan Hard to Handle?

An MSA (Medical Savings Account) May Be the Answer.

MSA Advantages:

- MSA deposits along with medical plan premiums may be tax deductible.
- MSAs encourage employees to be more involved in healthcare decisions.
- MSAs allow you & your employees to accumulate funds tax-deferred.
- An MSA empowers you with more control over costs while adding flexibility.

Come learn the facts about MSAs at the MMBR/Prime Health Care seminar in your area.

Friday, Oct. 10th, 8:30 a.m. - 10:00 a.m., Holiday Inn, Duluth

Wednesday, Oct. 15th, 8:30 a.m. - 10:00 a.m., Radisson Suites, St. Cloud

Thursday, Oct. 16th, 8:30 a.m. - 10:00 a.m., Holiday Inn, Mankato

Tuesday, Oct. 28th, 8:30 a.m. - 10:00 a.m., Sheraton Midway, I-94 at Hamline, St. Paul

Thursday, Oct. 30th, 8:30 a.m. - 10:00 a.m., DoubleTree Park Place (formerly Sheraton Park Place), Hwy 394 West of Hwy 100, Minneapolis

To reserve your place, call MMBR at 800-298-6627.

MMBR

Minnesota Medical Business Resources
Owned By MMA & HMS

Baltimore

Rates, Trends, & Data

New Estimates Reveal Higher Prevalence of Domestic Violence

According to a U.S. Justice Department study, 243,000 people were treated for injuries inflicted by an intimate partner in 1994—four times as many as previously estimated. The new estimate was compiled by examining emergency hospital admissions rather than by the more common but less precise practice of surveying police records or interviewing victims. More women than men made up the 243,000 people treated for injuries inflicted by an intimate partner (spouse, former spouse, current or former boyfriend or girlfriend). Of the 1.4 million people treated for nonfatal injuries from willful or suspected intentional acts of violence, nearly half were injured by someone they knew. Bruises and bumps accounted for slightly more than one-third of the injuries overall.

Despite the high number of injuries, the Justice Department asserts that domestic violence is seriously underreported.

More Youth Say They Know of Drug Use by Classmates

The number of 12- to 17-year-olds who say friends or classmates have used cocaine, heroin, or LSD has risen sharply in the last year, according to a poll conducted for the National Center on Addiction and Substance Abuse at Columbia University. The poll found that 56 percent of the youths surveyed said they knew someone using at least one of the hard drugs, an increase from 39 percent in 1996.

The increase was greatest among 12-year-olds, 23.5 percent of whom said friends or classmates used the drugs, up from 10.6 percent last year. The survey also found support for the theory that adolescents who use cigarettes, alcohol, or marijuana—so-called gateway drugs—run a greater risk of using harder drugs as they get older.

Suicide Rate Is Highest in West, Lowest in Northeast

The Western region of the United States had a suicide rate of about 14.1 suicides per 100,000 people between 1990 and 1994, the highest in the country, according to the Centers for Disease Control and Prevention. The rate was lowest in the Northeast, at 9.3 per 100,000. The rate in the Midwest



Emergency Physicians

BE/BC Emergency or Family Practice physicians are needed for the ED at St. Francis Hospital in Shakopee, a southwestern suburb. Full benefits provided.

Urgent Care Physicians

Opportunities available for Urgent care in Shakopee and Chaska, looking for Family Practice and Internal Medicine with pediatrics experience. Permanent part-time and moonlighting positions available, evening and weekend hours.

For Additional Information:

Debbie Modder
Allina Health System
Route 80775
5601 Smetana Drive
Minnetonka, MN 55343
612-992-3094 / 800-248-4921
Fax: 612-992-3669

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Occupational Health
Ob/Gyn
Pediatrics

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES

was 11.4 and 13.1 in the South. Minnesota's suicide rate for 1990 through 1994 was 11.5 overall.

CDC researchers weren't sure why the suicide rate was higher in the West. Unemployment and isolation may be more prevalent in those states. Also, drug and alcohol overdoses were twice as frequent in the West as in the Northeast, the CDC said. Guns were the top method of suicide in every region.

Chiropractors Cite High Use of Services

A survey conducted by a market research firm for the state's chiropractors showed that nearly half of Minnesota adults have used a chiropractor at some point, a significantly higher number than the national average of 32 percent. Chiropractors hope the survey results will give them more leverage in their long-standing effort to receive payments without physician referrals from insurance companies and HMOs. The survey, conducted for the Minnesota Chiropractic Association, confirms other findings showing that chiropractic care is one of the most-used alternative health care treatments.

Malpractice Awards Have Doubled in 10 Years

The average payment to injured patients in medical malpractice court cases nearly doubled between 1985 and 1995, according to a study by the Physician Insurers Association of America (PIAA). The average indemnity payment in 1994 was $398,426, compared with an average of $211,711 in 1985 (calculated in 1995 dollars). The study is based on information gathered from PIAA's database of more than 150,000 medical malpractice claims.

In 1985, the average cost of defending a malpractice action was $6,638 ($9,300 in 1995 dollars). By 1995, the cost had risen to $19,346. Typically, injured patients receive just half of every dollar spent to compensate them for the injury. The survey also found that approximately $737 million was spend in 1995 to defend meritless claims, and payment to expert witnesses is one of the fastest rising costs in the defense of claims.

Medical Research

Emotionally Connected Adolescents Are Healthier

Adolescents who feel connected to their families and schools are generally healthier than those who don't, according to a report published in the September 10 *Journal of the American Medical Association.* Michael Resnick, Ph.D., from the University of Minnesota, and colleagues provided the report as a result of the National Longitudinal Study on Adolescent Health.

The researchers found that emotionally connected adolescents were less likely to suffer from emotional distress, have suicidal thoughts and behaviors, use violence, smoke cigarettes, drink alcohol, or smoke marijuana. Factors that increased the risk for emotional distress were working 20 or more hours per week, appearing "older than most" in class, and repeating a grade.

A parent's physical presence in the home was less significant in the overall health of the adolescent than feelings of warmth, love, and caring from parents.

Diet Drugs Pulled off Market

Redux (dexfenfluramine) and Pondimin (fenfluramine), two of the most popular diet drugs, were taken off the market in September. The Food and Drug Administration (FDA) urged patients to stop using the drugs and to see their doctors, according to a Minneapolis-based *Star Tribune* article.

Fenfluramine was often taken with the drug phentermine in a combination known as fen-phen to control food cravings. Patients can no longer use the combination.

Withdrawal of the drugs was prompted after researchers at the

Mayo Clinic in Rochester released a study in July linking the drugs to serious heart valve damage. The FDA later received additional reports of the same valve disorder in patients, including some using Redux. The FDA reviewed the records of almost 300 patients taking the drugs and found abnormal echocardiograms in nearly 30 percent of them.

Fen-phen and Redux also increase the risk of pulmonary hypertension, researchers found.

Discovery of Lyme Disease Antibody Could Speed Diagnosis

Lyme disease researchers have discovered an antibody that could help physicians quickly determine whether the infection has invaded the nervous system. Researchers found the antibody in 75 percent of patients they tested who had clear symptoms of neurological Lyme disease. The immune system makes the antibody almost immediately after the disease invades the spinal fluid, which can happen just days after a tick bite.

Most current tests look for infection in the blood because spinal fluid tests are unreliable. A commercial test for the antibody could be patented in about three years, said **Patricia K. Coyle, M.D.**, a neurology professor at the State University of New York-Stony Brook and collaborator on the project with lead author **Steven E. Schutzer, M.D.**, an immunologist and associate professor at the University of Medicine and Dentistry of New Jersey–New Jersey Medical School in Newark. Their findings were published in the *Journal of Clinical Investigation.*

Atorvastatin Is Most Effective Cholesterol-Lowering Drug

Atorvastatin does a better job of lowering LDL cholesterol than the other four drugs currently on the market, researchers at the University of Minnesota and elsewhere have found. But all five drugs effectively reduce both LDL and triglyceride levels, so patients who cannot reach recommended levels with one drug should switch to another one, said **Donald Hunninghake, M.D.**, professor of medicine and pharmacology at the University of Minnesota. Hunninghake presented results of the study, which was conducted in 1996, at the annual European Society of Cardiology meeting in Stockholm, Sweden, in August.

The researchers found that patients who took 80 milligrams of atorvastatin a day lowered their LDL readings by 55 percent to 60 percent. The drug received FDA approval earlier this year and has claimed a significant share of the market. The other four cholesterol-lowering drugs are simvastatin, pravastatin, lovastatin, and fluvastatin.

Gay Male Youth Are More Likely to Attempt Suicide

Young gay men are seven times more likely to report attempted suicide than their heterosexual peers, researchers at the University of Minnesota found. The study, led by **Gary Remafedi, M.D.**, compared all junior and senior high school students in the Minnesota Adolescent Health Survey who identified themselves as homosexual or bisexual to heterosexual students with similar demographic characteristics. The study appeared in the August issue of the *American Journal of Public Health.*

Twenty-eight percent of bisexual and homosexual males reported a suicide attempt—seven times the percentage of heterosexual males. However, bisexual, homosexual, and heterosexual females had similar rates of suicidal thoughts, intentions, and attempts.

"Homosexuality itself does not cause suicidal thoughts and behaviors, based on the apparent absence of a link between sexual orientation and suicidality in females," Remafedi said. "The risk of suicide among gay male youth is probably mediated by other factors like substance use, being labeled as 'different,' or verbal and physical harassment."

Weigh The Facts!

Benefits to clinics, hospitals and practitioners include:
-Large pool of seasoned physicians.
-Integral part of medical referral network.
-Current in medical care policies, procedures and protocol.

To physicians of all specialties:
-Confidentiality prioritized.
-Financial incentives.
-Medical malpractice.
-Personalized service tailored to your needs.



Whitesell
Medical Locums, Ltd.

Eight First Avenue South
Buffalo, MN 55313
1(800) 876-7171
1(800) 295-6373
***Local* 682-5218 or 682-5906**
FAX (612) 682-4791

Proposed FDA Ban Prompts Ex-Lax Maker to Pull Products

The maker of Ex-Lax, the country's top-selling laxative, pulled three versions of its products off shelves in August after the FDA announced a proposed ban on the ingredient phenolphthalein, which has been associated with cancer in rats and mice. As soon as the agency publicized its intentions, Novartis, the Swiss-based pharmaceutical conglomerate that makes Ex-Lax, withdrew its regular, maximum relief, and chocolate formulas from the market. Reformulated versions will contain senna, a plant-based ingredient commonly used in other laxatives.

Novartis said it believed that after more than 90 years of use, Ex-Lax was safe, but the company would stop using phenolphthalein to avoid consumer confusion. Neither of the other two top-selling

products, Metamucil and Phillips, contains phenolphthalein.

The FDA said that although there have been no reports of phenolphthalein-associated cancer in humans, the compound's benefits do not outweigh its risks. Animal studies showed that at high doses, phenolphthalein could damage a vital gene—p53—that suppresses tumors.

Worldwide Study Hopes to Detect AIDS in Early Stages

While some people die from complications of AIDS within a year of being infected with HIV, others are healthy and asymptomatic 14 years later. A team of researchers from the University of Minnesota and universities in Geneva, Switzerland, and Sydney, Australia, aim to find out why.

"We would like to know why some people go so rapidly and why some seem to be able to live with the infection," said **Timothy Schacker, M.D.**, head of the University of Minnesota AIDS program, in a *Star Tribune* article.

The project, supported by the National Institutes of Health, is designed to detect AIDS infection in the early stages, before conventional HIV tests would give a positive reading. Researchers will monitor the progress of the virus and of therapy. The team will use the polymerase chain reaction technique to measure the amount of HIV in the blood of patients soon after they are infected, before they have seroconverted.

Knowing what happens during the period between the time of infection and the time the body begins producing antibodies might help researchers learn how to treat the disease more effectively, said Schacker. MM

PVS
PHYSICIANS FOR A VIOLENCE-FREE SOCIETY

Preventing Violence Is Good Medicine

The mission of Physicians for a Violence-Free Society is to stop the cycle of family violence and promote the welfare of victims through support and education of health care professionals.

Join Us Now!

Physicians for a Violence-Free Society
P.O. Box 35528
Dallas, TX 75235-0528

(214) 638-4200
fax (214) 638-4225
pvs84@airmail.net



HealthEast Healing Center

Healing: To make sound, well, whole

The HealthEast Healing Center moves health care to a new level. We've merged years of practice in conventional medicine with a host of other healing traditions. It's an inclusive view, a holistic approach to health in which body, mind and spirit function as one.

The HealthEast Healing Center offers easy access to a host of healing resources — acupuncture, naturopathy, internal medicine, massage therapy, chiropractic, healing touch and much more — an unprecedented mix of therapies, services, and products that support health and healing.

We welcome referrals from physicians and other health professionals. Clients can also come to the Center on their own or register for one of our classes, access our comprehensive resource library, or purchase health related products from the HealthEast Healing Store.

Coming Soon From HealthEast...Choices In Healing

A conference featuring the best of conventional and complementary medicine
Saturday, November 1, 1997
Minnesota History Center, 345 Kellogg Boulevard West, St. Paul



Part 1 — 7:30 a.m. - 3:00 p.m. Offered For CME/CEU Credit Features Keynote Speakers:

Michael Lerner, Ph.D.
Featured on the PBS Bill Moyer's series, Healing and the Mind, and author of *Choices in Healing: Integrating the Best of Conventional and Complementary Approaches to Cancer.*

David Eisenberg, M.D.
Director of the Center for Alternative Medicine Research at Beth Israel Deaconess Medical Center and Harvard Medical School and author of *Encounters with Qi: Exploring Chinese Medicine.*

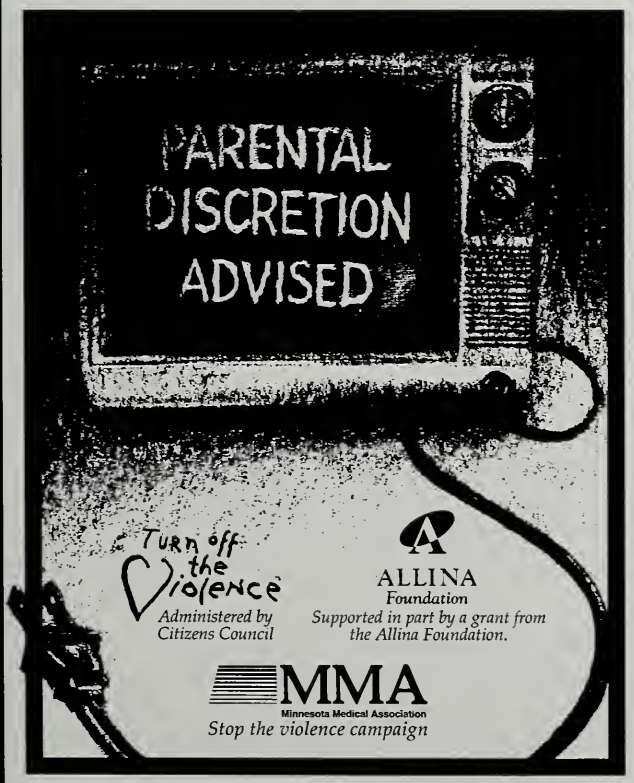


Part 2 — 3:00 p.m. - 9:00 p.m. Features Workshops In:

Immunoimagery • Chinese medicine and acupuncture • Deep massage • Spirituality and healing
Healing through nutrition and herbs • Healing touch and energy medicine

Dinner buffet and book signing with David Eisenberg, M.D., and Michael Lerner, Ph.D.

Presented by HealthEast WELLCare and the HealthEast Healing Center. Call HealthEast office of Medical Education at **(612) 232-5140** for further information.



Stop the media violence

Media violence is a health hazard to kids. As a physician, you can help by educating patients! Provide parents with information on taking charge of the media in their children's lives by limiting viewing, providing choices, and talking about what is being shown.

For further information, or to order posters and brochures to display in your office, contact:

Minnesota Medical Association
3433 Broadway Street NE, Suite 300
Minneapolis, MN 55413
612-378-1875



150 years of caring for the country 1847 - 1997

Make a commitment to your patients and your profession. Join or renew your membership in the AMA today.

American Medical Association
Physicians dedicated to the health of America

UNITED STATES POSTAL SERVICE™

Statement of Ownership, Management, and Circulation

(Required by 39 USC 3685)

1. Publication Title	2. Publication Number	3. Filing Date
Minnesota Medicine	3 5 1 9 - 0 0 0	10-1-97
4. Issue Frequency	**5. Number of Issues Published Annually**	**6. Annual Subscription Price**
Monthly	12	$40.00

7. Complete Mailing Address of Known Office of Publication *(Not printer) (Street, city, county, state, and ZIP+4)*
3433 Broadway Street NE, Suite 300, Minneapolis, Hennepin, MN 55413

Contact Person: Susan Rodsjo
Telephone: 612/378-1875

8. Complete Mailing Address of Headquarters or General Business Office of Publisher *(Not printer)*
3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761

9. Full Names and Complete Mailing Addresses of Publisher, Editor, and Managing Editor *(Do not leave blank)*

Publisher *(Name and complete mailing address)*
Minnesota Medical Association
3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761

Editor *(Name and complete mailing address)*
Charles Meyer, M.D.
3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761

Managing Editor *(Name and complete mailing address)*
Meredith McNab
3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761

10. Owner *(Do not leave blank. If the publication is owned by a corporation, give the name and address of the corporation immediately followed by the names and addresses of all stockholders owning or holding 1 percent or more of the total amount of stock. If not owned by a corporation, give the names and addresses of the individual owners. If owned by a partnership or other unincorporated firm, give its name and address as well as those of each individual owner. If the publication is published by a nonprofit organization, give its name and address.)*

Full Name	Complete Mailing Address
Minnesota Medical Association	3433 Broadway Street NE, Suite 300 Minneapolis, MN 55413-1761

11. Known Bondholders, Mortgagees, and Other Security Holders Owning or Holding 1 Percent or More of Total Amount of Bonds, Mortgages, or Other Securities. If none, check box → ☒ None

12. Tax Status *(For completion by nonprofit organizations authorized to mail at special rates) (Check one)*
The purpose, function, and nonprofit status of this organization and the exempt status for federal income tax purposes:
☒ Has Not Changed During Preceding 12 Months
☐ Has Changed During Preceding 12 Months *(Publisher must submit explanation of change with this statement)*

13. Publication Title	14. Issue Date for Circulation Data Below
Minnesota Medicine	September 1997

15. Extent and Nature of Circulation		Average No. Copies Each Issue During Preceding 12 Months	Actual No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies *(Net press run)*		9,737	9,200
b. Paid and/or Requested Circulation	(1) Sales Through Dealers and Carriers, Street Vendors, and Counter Sales *(Not mailed)*	0	0
	(2) Paid or Requested Mail Subscriptions *(Include advertiser's proof copies and exchange copies)*	8,630	8,797
c. Total Paid and/or Requested Circulation *(Sum of 15b(1) and 15b(2))*		8,630	8,797
d. Free Distribution by Mail *(Samples, complimentary, and other free)*		906	273
e. Free Distribution Outside the Mail *(Carriers or other means)*		63	64
f. Total Free Distribution *(Sum of 15d and 15e)*		969	337
g. Total Distribution *(Sum of 15c and 15f)*		9,599	9,134
h. Copies not Distributed	(1) Office Use, Leftovers, Spoiled	138	66
	(2) Returns from News Agents	0	0
i. Total *(Sum of 15g, 15h(1), and 15h(2))*		9,737	9,200
Percent Paid and/or Requested Circulation *(15c / 15g x 100)*		90%	96%

16. Publication of Statement of Ownership
☒ Publication required. Will be printed in the October 1997 issue of this publication.
☐ Publication not required.

17. Signature and Title of Editor, Publisher, Business Manager, or Owner	Date
Charles R Meyer M.D. Editor-in-Chief	9-25-97

I certify that all information furnished on this form is true and complete. I understand that anyone who furnishes false or misleading information on this form or who omits material or information requested on the form may be subject to criminal sanctions (including fines and imprisonment) and/or civil sanctions (including multiple damages and civil penalties).

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

OCTOBER 1997

Oct. 5-8 **The 13th Annual Echocardiography in Congenital Heart Disease Symposium** Mayo Foundation; Mayo Clinic, Rochester, MN. CONTACT: Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 8-10 **Internal Medicine Review** University of Minnesota; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 9-10 **Annual Orthopedic and Trauma Seminar** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 9-10 **Clinical Research Methods** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 10 **Sixth Annual Conference for CME Planners** Minnesota Medical Association; Northland Inn, Brooklyn Park, MN. CONTACT: Jane Phillip, MMA, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413; 612/378-1875 or 800/342-5662.

Oct. 15 **Domestic Violence Conference** Hennepin County Medical Center; HCMC, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 16 **Medical Staff Meetings** Hennepin County Medical Center; Whitney Hotel, Minneapolis, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

Oct. 16-17 **Obstetrics and Gynecology Annual Autumn Seminar** University of Minnesota; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 16-19 **American Society of Addiction Medicine's 10th National Conference on Nicotine Dependence** American Society of Addiction Medicine; Minneapolis Marriott City Center, Minneapolis, MN. CONTACT: Sandy Metcalfe, 4601 North Park Avenue, Chevy Chase, MD 20815; 301/656-3920.

Oct. 24-25 **Psychiatry in Practice: Honoring Tradition, Incorporating Innovation** Mayo Foundation; Siebens Building, Mayo Clinic Campus, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 24-26 **Lasers in Cutaneous and Cosmetic Surgery** University of Minnesota; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 24-26 **Obstetrics and Gynecology Annual Autumn Seminar** University of Minnesota; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Oct. 27-29 **Clinical Reviews 1997** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Oct. 30 **Geriatric Update for the Primary Care Physician** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Oct. 31-Nov. 1 **Nursing Home Medical Directors** University of Minnesota; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

NOVEMBER 1997

Nov. 10-12 **Clinical Reviews 1997** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 13-15 **Mayo Clinic Ob/Gyn Clinical Reviews** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 14 **E.T. Bell Pathology Symposium** University of Minnesota; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 14-15 **Laboratory Diagnosis of Fungal Infections** Mayo Medical Laboratories; The Founders Inn and Conference Center, Virginia Beach, VA. CONTACT: Julie McAdams, 200 First Street SW, Rochester, MN 55905; 507/284-8599.

Nov. 21-22 **Osteoporosis Conference** Hennepin County Medical Center; Doubletree Grand Hotel, Bloomington, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

FEBRUARY 1998

Feb. 27-Mar. 1 **Current Concepts of Erectile Dysfunction: Diagnosis and Treatment** Mayo Foundation; Caribe Royale Resort Suites, Lake Buena Vista, FL. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MAY 1998

May 5-8 **Fifth International Surgical Pathology Symposium** Mayo Medical Laboratories; Munich, Germany. CONTACT: Kathy Bates, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; E-mail: Kbates@mayo.edu, fax 507/284-4542, fax on demand 800/263-6296 or 507/282-0461.

CENTRACare CLINIC

CentraCare Clinic, a multispecialty group of 87 physicians based in St. Cloud, currently has the following openings within our multisite system:

Noninterventional Cardiology
Internal Medicine (Little Falls)
Gastroenterology
Neurology
Family Practice (Melrose)
Infectious Disease

CentraCare Clinic is a progressive, rapidly growing group offering an outstanding lifestyle, compensation and benefits. Our clinics are conveniently located between the Twin Cities and prime Minnesota lake areas.

Contact: John Schnettler
Physician Recruiter
St. Cloud Hospital
1406 Sixth Avenue North
St. Cloud, MN 56303
800-835-6652



ALEXANDRIA CLINIC, P.A.

The Alexandria Clinic, P.A., is a 32-physician multispecialty group currently recruiting additional physicians in the following specialties:
- DERMATOLOGY
- ENT
- INTERNAL MEDICINE

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., October 15 for December ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

Olmsted Medical Center is seeking BC/BE physicians in family medicine. Great opportunity for well-trained physicians to join a 75-physician multispecialty group in a dynamic, progressive practice. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes 10 branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (*5/96-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Part-time Neurologist wanted for multidisciplinary office. No call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Urgent Care Physicians: We are a growing urgent care practice looking for BC/BE physicians to work full or part time to staff our four clinics. We currently have three locations in the metro area and one location in Mankato and are planning on expanding in 1997. Please contact Cara Auge at 612/593-9818 or 800/511-2820 for more information on joining our growing practice, or send inquiries to 9800 Shelard Parkway, #210, Plymouth, MN 55441. (4/97-R)

Office Space for Rent: Medical/dental only, Burnsville, 35W/35E interchange. Modern, 2,000 square feet. Garage parking. Call Dick, 612/435-4144. (8/97-R)

Ob/Gyn BC/BE to join progressive 33-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographic referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AOA/EOE. *3-11/97

Mankato, Minnesota: Full-time psychiatrist. Excellent opportunity for BC/BE psychiatrist to join our multidisciplinary team. Competitive salary and benefit package. Mankato is a high-quality town 70 miles south of Minneapolis. Excellent schools and recreational activities. For more information, contact Ed Sathoff, M.D., or Patricia Blumenreich, M.D., at 507/387-3195, or send/fax CV to Psychiatric Clinic, 410 Jackson Street, Suite 200, Mankato, MN 56001; Fax: 507/625-2224. 3-11/97

Family Practice—rural but near: Independently owned primary care group located 45 minutes from Minneapolis seeks family practice physician. Growing community offers professional options for significant other, walking and biking trails, good school choices, strong economic base, and safe environment. Practice offers four-day clinic week, 1:6 call, supportive colleagues, new facilities, and dedicated staff. Call Verne Meyer, 800/967-2711, or fax CV to 320/587-7252. E-mail: delacore@hutchtel.net. 3-11/97

Urgent Care Physicians

Urgent care openings at five Procare sites throughout the Twin Cities. BE/BC Family Practitioners and Internists, comfortable with pediatrics, to work evenings, weekend, and holidays. Permanent part-time (32-40 hours every two weeks) with benefits. Moonlighting needed and will consider residents.

MERCY & UNITY HOSPITALS
ALLINA HEALTH SYSTEM

For more Information:
Allina Health System
5601 Smetana Drive Route 80775
612-992-3094 / 800-284-4921
Fax: 612-992-3669

Family Practice—Chetek: Luther Midelfort–Mayo Health System, a thriving 160-physician multispecialty clinic and hospital in Eau Claire, Wisconsin, is seeking a BC/BE family practitioner for our Chetek, Wisconsin, office. A desire to practice ob is essential. General call of 1:10 and ob call of 1:7 is expected. Physicians do not have first call in the emergency department. Will share a newly remodeled office with one other family practitioner. Chetek, located 40 miles north of Eau Claire, is in the heart of resort country. Located on a chain of six connecting lakes, Chetek offers four-season recreation for the outdoor enthusiast. For further information, contact Christie Blink, Physician Recruitment Coordinator, at 800/573-2580, or fax 715/838-6688. 3-11/97

Nationwide Opportunities available in cardiology, emergency medicine, ENT, family practice, internal medicine, occupational medicine, pediatrics, cardiothoracic, and general surgery. These practices range from large multispecialty clinics to single specialty groups to a regional HMO. Locations include resort communities, small, close-knit towns, and metropolitan/suburban settings. Live and practice in a beautiful Lake Michigan shoreline community or a town nestled in a pristine forest. Let us help you choose a practice that fits your lifestyle. Call Strelcheck and Associates 800/243-4353. *1-10/97

FAMILY PRACTITIONERS: ARE YOU LOOKING FOR...

A CHALLENGING CLINICAL PRACTICE?

- Join 3 F.P. and 2 N.P. in a clinic with 25,000 annual patient visits
- Financially stable 31-bed hospital, 74-bed LTC, and HH agency
- Access to 26 outreach specialists
- Including Operative, Obstetric and Emergency Services

A GOOD LIFE?

- Working flexible 4.5 day week with 1:4 weekend and night call
- A progressively diverse rural community
- Within two hours of Fargo and Sioux Falls and three hours of Twin Cities
- Recreation: Big Stone Lake, 18-hole golf course, National Wildlife Refuge

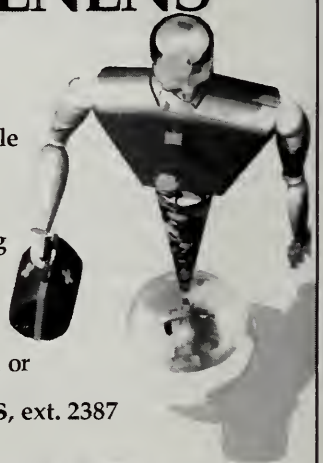
A SUPPORTIVE COMMUNITY?

- Community-based Health Care Foundation with $1 million dollars pledged
- Providing competitive package including:
  - Guaranteed starting salary w/incentive
  - Two year housing allowance
  - Educational loan repayments

C.V. in confidence to Administrator
Ortonville Area Health Services,
Ortonville, MN 56278
Phone: (320)839-2502; FAX: (320)839-2507. EOE.

Staff Care, Inc.
"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS



- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging

Ask for :
John Moberly, ext. 2381 or
Melanie McReynolds, ext. 2387

(800) 685-2272
http://www.locumsnet.com

Staff Care is proud to sponsor *the Country Doctor of the Year Award*

Unable to place J-1 or H-1 physicians

Mankato, Minnesota: Live in a safe, family-oriented community, just 75 miles from Minneapolis/St. Paul. Mankato is rated one of the 10 most livable small cities in the United States. Experience the best of both worlds: a friendly community with excellent schools, many recreational activities, and quality lifestyles within easy driving distance to the wonders of the Twin Cities. Practice in the moderate volume emergency department with all-BC emergency medicine group. Seeking same or BP emergency medicine. Mayo-affiliated hospital. Send CV to Frank Ellesmere, Director, physician placement, PO Box 8673, Immanuel St. Josephs-MHS, Mankato, Minnesota 65002-8673, or call 800/628-3707, fax 507/625-1847. E-mail: ellesmere.frank@mayo.edu. 1-10/97

Psychiatry—rural but near: Seeking the fourth staff psychiatrist for an expanding community psychiatry center. Practice offers highly qualified colleaues, a multidisciplined approach, beautiful facilities, competitive salary, and benefit programs. This growing community, located within one hour of Minneapolis, offers professional options for significant other, walking and biking trails, good school choices, strong economic base, and a safe environment. Contact Verne Meyer, 800/967-2711, fax 320/587-7252, or E-mail: delacore@hutchtel.net. *3-12/97

Minnesota: BC/BE general orthopedist or medical orthopedist needed to complement a well-established solo orthopedic practice. Competitive salary guarantee and benefits. Excellent schools, recreation, and outdoor activities. Subspecialty training welcome. Please fax resume to Lori at 507/238-1997. 3-11/97

Occupational Medicine—Minneapolis: BC/BE occupational medicine physician needed to join the 13-member occupational medicine department of a 422-physician multispecialty clinic in desirable Twin Cities area. We serve over 2,000 different client companies in the metro area and region. Opportunity for teaching and clinical research is available. Comprehensive, generous benefit program. For additional information, contact Patrick Moylan at 612/993-5986 or send CV and letter of inquiry to Mr. Moylan, Professional Practice Resources, Park Nicollet Clinic, HealthSystem Minnesota, 3800 Park Nicollet Boulevard, St. Louis Park, MN 55416, or fax 612/993-2819. 2-11/97

Neurologist, Oncologist, Urgent Care, ENT, Dermatologist

There are immediate openings at Brainerd Medical Center for the following specialties: Neurology, Oncology, Urgent Care, Ear, Nose and Throat, and Dermatology.

Brainerd Medical Center, P.A.

- 36-physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota

- Surrounded by the premier lakes of Minnesota
- Located in central Minnesota less than 2 ½ hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:

- Curt Nielson
  (218) 828-7105
  or (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

FAMILY PRACTICE MEDICAL CENTER
OF WILLMAR, P.A.

Family Practice Opportunity: Seven-family physician group seeks additional full-time family physician. Family Practice Medical Center of Willmar, Minnesota, P.A., is a physician-owned clinic located in the regional health care center for west-central Minnesota. Broad secondary specialist services provided in community, 24-hour ER physician coverage, and after-hour nurse triage service. Teaching opportunities as clinical faculty for University of Minnesota. Guaranteed salary first year, with a full range of benefits and the opportunity for ownership. Outstanding quality of life including four-season recreational opportunities, strong community economy, excellent educational system, and a regional retail center. Inquiries to Gary McDowell, Administrator, at 320-235-7232, or fax 320-231-8602.

"...what Allina did for our careers was great; what they did for our families was amazing."

Allina knows what's important to our physicians. That's why we've created a progressive, not for profit health organization that values your time and talent. We offer desirable call schedules and excellent physician support, allowing you to do the work you love, without abandoning your loved ones. Allina is currently seeking physicians in the following categories: Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, Locum Tenens, and Dermatology.

Our Minnesota/Wisconsin locations have numerous metro and rural opportunities —along with our rewarding career structure, excellent compensation package, and family relocation assistance.

If you love your work, you'll love Allina.

Call our Physicians Services Group
612-992-3093 or 1-800-248-4921
Fax 1-612-992-3669
Allina Health System . Route 80775
5601 Smetana Drive . Minnetonka, MN 55343

ALLINA
HEALTH SYSTEM

A place to practice, a place to live

Mpls St Paul magazine ranks Owatonna one of Minnesota's eight great small towns. We enjoy:
- Proximity to the Twin Cities
- Excellent schools
- Pleasant neighborhoods
- Recreational opportunities

A growing group practice of 28 physicians, we want to expand our physician team in:
- Family practice
- Internal medicine
- Obstetrics and gynecology

For more information contact David Berg, Owatonna Clinic administrator, at 507-455-4441.

Owatonna Clinic
Mayo Health System

OCTOBER 1997 INDEX TO ADVERTISERS

Acute Care Inc. 52
Affiliated Community Medical Centers 46
Air Force Health Professionals–Ft. Snelling ..... Cover 3
Alexandria Clinic, P.A. 64
Allina Health System 31, 58, 66, 68
Aspen Medical Group 32
Brainerd Medical Center 67
Centra Care Clinic 64
Central Minnesota Group Health Plan 52
Chisago Health Services 20
Fairview Clinic Services 57
Family Practice Medical Center 67
First Call Physicians, Inc. 49
Franciscan Skemp Healthcare 51
Gillette Children's Specialty Healthcare 9
Global Holidays 51
HealthEast Healing Center 61
HealthPartners 3, 20
HealthPartners Regions Hospital 52
Hennepin Medical Society 32
Leonard, Street & Deinard 49
Medical Protective Company ..... Cover 2
Midwest Medical Insurance Co. 23
MMBR 41, 50, 55, 56
Multicare Associates of the Twin Cities 58
North Memorial Medical Programs 20
Norwest Center 54
Ortonville Area Health Services 66
Owatonna Clinic 68
St. Luke's Hospital 13, 46
Staff Care, Inc. 66
Star Tribune 46
THC Minneapolis 5
University of Minnesota ..... Cover 4
Whitesell Medical Locums, Ltd. 59

Minnesota Medicine

JOURNAL OF CLINICAL AND HEALTH AFFAIRS

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE
STACKS
NOV 18 1997
REC'D NOT IN CIRC



DEATH WITH DIGNITY

The physician's role

NOVEMBER 1997



THE
MEDICAL PROTECTIVE COMPANY ®

Professional Protection Exclusively since 1899

To reach your local office, call 800-344-1899.

GOLD CORPORATE AFFILIATE
MGMA
FOUNDED 1926
PROGRAM UNDERWRITER

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover illustration by Jim Dryden.

FACE TO FACE

6 **Lessons from the Monastery** ..... Anne Welsbacher
At St. John's Abbey and University, Benedictine monks are offering Rebecca Hafner, M.D., insights into helping patients die well.

PERSPECTIVES

10 **Just Over the Horizon** ..... Andrea Matthews
A daughter is grateful that her father's physicians knew how far to push before letting go.

COMMENTARIES

14 **Hospice: An Alternative to Needless Suffering** ..... Matt Malloy
Absent from the physician-assisted suicide debate is an option that provides physical, emotional, and spiritual relief for the dying.

15 **Legal Aspects of Pain Relief for the Dying** ... Phebe Saunders Haugen, J.D.
Fear of legal repercussions should not deter physicians from doing all they can to relieve pain in dying patients.

FEATURE STORY

20 **Bringing Bioethics Theory to the Bedside** ..... Howard Bell
Ethics committees are shedding light on end-of-life decision-making.

CLINICAL & HEALTH AFFAIRS

27 **Pain Control at the End of Life** ..... Thomas E. Elliott, M.D., F.A.C.P.

SPECIAL REPORT

42 **Hospice Care for Terminally Ill Hmong Patients: A Good Cultural Fit?** ..... Dorothy E. Vawter, Ph.D., and Barbara Babbitt, M.A., R.N.
Differing beliefs about health practices may lead to misunderstandings between hospice staff and Hmong patients.

MEDICINE LAW & POLICY

45 **Physician-Assisted Suicide: The U.S. Supreme Court Weighs In** ..... Patricia L. Franklin, J.D.
The U.S. Supreme Court finds no constitutional right to physician-assisted suicide (plus comments from the 1997 Milton G. Ettinger lecture on physician-assisted suicide by Arthur Caplan, Ph.D.).

BOOK REVIEWS

50 **Choices at the End of Life: An Annotated Bibliography** ..... Charles R. Meyer, M.D.

33 The Monitor

Highlights ..... *Changes proposed in Medicare direct contracting • MMA urges Congress to hold out for stronger tobacco measures*

DEPARTMENTS

2 ..... Editor's Note

26 .... Author Instructions

52 .... News Clips

58 .... MMA Sponsors

60 .... CME in Minnesota

61 .... Classified Ads

64 .... Index to Advertisers

Ministering to Dying Patients

In a recent *New Yorker*, Jerome Groopman, M.D., an oncologist at Harvard's Beth Israel Hospital, writes about a patient with metastatic renal cell carcinoma. Kirkland Bains, a hard-driving venture capitalist, came to Groopman with death sentences from three other prominent oncologists. Refusing to accept "I can't help you," Bains grasped at the investigative chemotherapy Groopman reluctantly suggested. Miraculously, the tumors melted and Bains achieved a four-month remission. Then a spinal cord relapse sent Bains back to Groopman. This time the patient was defeated and resigned. During his remission, he had reviewed his life and found it wanting. He rejected attempts at consolation, stating it was "too late to relive" his life. He died with harsh self-judgment.



"Of all our jobs as physicians, perhaps none is as psychologically intricate and emotionally important as ministering to the dying."

Another patient with renal cancer arrived at my office. He, too, had been told nothing could be done. He had gastrointestinal bleeding from a tumor that had invaded his intestines. Despite the futility of treatment, he requested transfusion support, NG suction, and angiographic embolization, first to stop the bleeding, then to ablate the tumor. Although he spent some rewarding time with his family, he died without accepting his death.

Two patients, same disease, same "death sentence," same stubborn reaction to the news, but different final paths—one of bitter final acceptance, the other of denial. The stories of terminally ill patients are compelling, their memory enduring. Of all our jobs as physicians, perhaps none is as psychologically intricate and emotionally important as ministering to the dying. To help doctors do that job better, the November *Minnesota Medicine* examines a number of end-of-life issues, including hospice, pain control, and physician-assisted suicide.

Physicians can do better at controlling pain. Tom Elliott, M.D., provides a useful primer on pain management (page 27). He urges physicians to educate and guide patients and families through the dying process by "helping redefine hope and assisting with the search for meaning and growth in the last phase of life." Phebe Haugen, J.D., counsels (page 15) that physicians need not fear administering narcotics for pain relief; the law distinguishes between mercy killing and pain control.

Physicians can do better at communicating. Rebecca Hafner, M.D.—profiled in this issue (page 6)—calls on the medical profession to demedicalize terminal illnesses, give patients and families choices about care, and help them to understand that death is not a curable illness.

Physicians can do better at understanding death in our culture. Death is the ultimate renunciation of youth in a society that extols youth and beauty. Death represents a failure of technology for patients and physicians who expect daily medical miracles. A more realistic understanding of death would lead to wider use of hospice and comfort care. If terminally ill patients knew they would be comfortable in their final days, perhaps Dr. K.'s simplistic solution would lose its appeal, and the whole physician-assisted suicide controversy would die—naturally.

And physicians can do better at ministering. At the end of life, our role changes. Although patients still need our drugs, they also need us to listen. For terminally ill patients, we need to focus not on saving lives, but on shepherding them.

It doesn't always work. Neither of the two cancer patients left life peacefully. Groopman couldn't soften the pain of an empty life. I couldn't lead my patient to serenity. But, just as we learn new procedures and treatments, we must become skilled at sharing our patients' deaths.

–Charles R. Meyer, M.D., Editor-in-Chief



FIND *the* BRIGHT SIDE *of caring for a* DIFFICULT *patient*



If you're dealing with the challenges of aggressive behavior, failing cognitive abilities, or poor functioning in an elderly client, there is hope. Under the care of our Geriatric Behavioral Program, elderly patients suffering from Alzheimer's disease or other forms of dementia have seen significant improvements.*

With skill and sensitivity, our behavioral professionals provide individual attention in a small, patient-centered facility. Our gentle, cohesive approach helps restore patients' ability to function and reason. We help them return to their residential setting with dignity and confidence. Most of all, we can help find a brighter side to living again.

* Based on objective assessment tools.

NURTURING
HUMAN POTENTIAL

HealthEast Bethesda Lutheran Hospital & Rehabilitation Center

559 Capitol Boulevard St. Paul, MN 55103

1-800-566-2720

http://www.healtheast.org

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editors
Lee J. Engfer
Susan Rodsjo

Assistant Editor
Juliet Ramotar

Graphic Designers
Lee J. Engfer
Mike May
Susan Rodsjo

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine.* The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/DIAL MMA (342-5662).

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Seymour Handler, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Jane Haugen West, M.D.
Barbara P. Yawn, M.D.
Meredith McNab, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine.* Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1997-98 Officers

President
Kent S. Wilson, M.D.

President-Elect
Judith F. Shank, M.D.

Chair, Board of Trustees
Paul C. Matson, M.D.

Vice President
Anthony C. Jaspers, M.D.

Secretary
Robert G. Milligan, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Blanton Bessinger, M.D.

Vice Speaker of the House
Gary D. Hanovich, M.D.

Past President
Raymond G. Christensen, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Kendra Flanagan

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Keith D. Larson, M.D.

West Metro
Timothy J. Crimmins, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth W. Crabb, M.D.
Lyle Munneke, M.D.
Bruce Norback, M.D.
Thomas L. Peyla, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

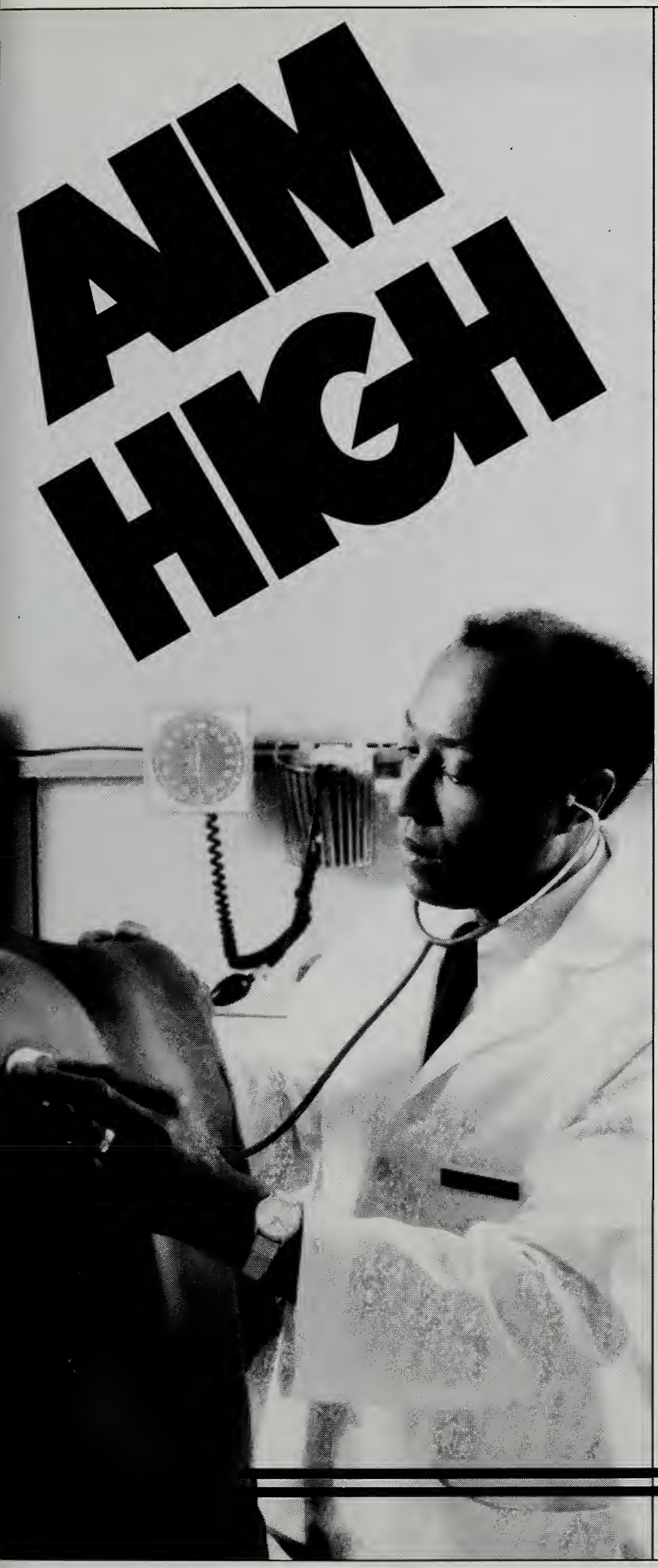
MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/DIAL MMA (342-5662)

Fax: 612/378-3875

E-mail: mma@mnmed.org

Web site: www.mnmed.org



SPECIALIZE IN AIR FORCE MEDICINE.

ER Physicians. Radiologists. OB/GYNs and other specialists! Today's Air Force gives you the freedom to specialize without the financial overhead of running a private practice. Talk to an Air Force medical program manager about the tremendous benefits of becoming an Air Force medical officer:

- No office overhead
- Dedicated, professional staff
- Quality lifestyle and benefits
- 30 days vacation with pay each year

Examine your future in the Air Force. Learn if you qualify. Call

USAF HEALTH PROFESSIONS
TOLL FREE
1-800-423-USAF

AIR FORCE

Lessons from the Monastery

Helping People 'Die Well'

At St. John's Abbey and University, Benedictine monks are giving Rebecca Hafner, M.D., perspective on how to put patients back in control of their own dying.

By Anne Welsbacher

Rebecca Hafner, M.D., lives so close to the abbey at St. John's that she can hear the bells toll when a member of the monastery dies. The fact that she already knows of each death before its public announcement underscores the multiple roles she plays in her work—and her close proximity, literal and figurative, to the community she serves.

Hafner is an ethicist and medical director at St. John's Abbey and University in Collegeville. She is a family physician who cares for the standard residents of a college campus—students, faculty, and staff. But, Hafner emphasizes, St. John's is not like other campuses; the life force of the campus is the monastic community, a group of more than 200 men who have chosen to live together as a community according to the Rule of St. Benedict.



PHOTOGRAPH BY JOHN NOLTNER

A Community Affair

"My work with the Benedictine community reinforces the end-of-life lessons I learned growing up in a small farming community in North Dakota," says Hafner, who studies changes in the way society deals with death. "There wasn't access to a lot of medical technology in our area, but there was such a strong sense of community. In fact, the mere *rumor* of a death in the family would bring an outpouring of support."

Traditional rituals surrounding death and dying offered time for healing and brought families together, says Hafner. Family and community support allowed the dying to think about how to spend their remaining days—and ensured that they would not die alone. Rituals such as community gravedigging, cooking, and sitting with the family served important functions during these times of transition. Family members got the chance to say goodbye and reminisce.

Modern technology, however, has turned death into a "medical event," with far-reaching consequences, asserts Hafner. "Part of the reason there's so much interest in physician-assisted suicide," she maintains, "is because people have been written out of any sort of control in the choices made around the dying process. We have robbed families and communities of the responsibility they had for being part of the dying process.

"As medical professionals, we don't always do a good job of helping people die well," says Hafner, who argues that physicians and society need to "demedicalize" the dying process and become comfortable once again with the fact that death is not a curable disease. "For physicians, that doesn't mean abdicating our therapeutic responsibilities. It means learning to be more collaborative and recognizing that we, too, are part of the community.

"There are few things in medicine where there's only one right answer," Hafner continues. "I try to give all patients, not just the dying, as much freedom and information as possible to help them make their choices."

Bridging Two Disciplines

Hafner received her M.D. from the University of North Dakota School of Medicine and took ethics classes at Georgetown University and the University of Washington in Seattle. She also earned an M.B.A. in health care management from the University of St. Thomas. But that program didn't include any ethics classes, so Hafner found a bioethics class taught by two theologians at St. Paul Seminary School of Divinity at the University of St. Thomas.

After talking with Hafner, one of those theologians realized that the health care management program needed an ethics component. And, says William McDonough, assistant professor of moral theology, "[I also learned that] two moral theologians should never be teaching an applied ethics course!"

He and Hafner team-taught a biomedical morality class for three years. Because of Hafner's influence, McDonough says, applied classes are now routinely taught by practitioners in partnership with theologians. "She's very persistent. She pushed the envelope to get what she needed to be competent in her field. And then,

when she got into our class, she helped *us* push the envelope again, to ask 'Where do we go from here?' I'd be delighted to see people with clinical backgrounds also getting backgrounds in ethics, because we need those interdisciplinary conversations."

As a physician-ethicist, Hafner says she is particularly interested in the notion of community and its role and influence in ethical decision-making. "As Americans, we have a very weak concept of the common good. As a society, we have long emphasized individual rights. In fact, almost all of the landmark medical ethics cases deal with rights of individuals. An intriguing but difficult research challenge would be to look at how outcomes differ for patients dying in a strongly supportive community. My experiences here at St. John's certainly suggest that we die better 'in community.'

"That's not to say we can return to the small-town life of the '50s and '60s—and most of us will not end our days as members of a monastery," says Hafner. "So where and how do our patients and families find support during their last days—particularly when our families may be scattered coast to coast?"

Hafner sees some hopeful signs: "The growth of the hospice movement is one. Neighborhood organizations, block clubs, and church-sponsored programs are actively seeking to build community back into the way we live. As our society ages, we will need such organizations to grow into communities that can also support our patients, our families, and ourselves as we die."

Hafner says she appreciates the sense of community she has found at St. John's. On a busy day during the school year, she sees about 25 patients, both students and monks, compared with the typical 40 patients she saw each day during a stint with an HMO. "I cherish the opportunity to have a relationship with my patients," she says of her current position.

In addition to her work with monks and students at St. John's, Hafner is an active member of the Minnesota Medical Association's Committee on Ethics and Medical-Legal Affairs, is on staff at St. Cloud Hospital, and has been involved with the hospital's family practice residency program. She is also a mom, to a 9-year-old son and two daughters, ages 13 and 17.

"The real challenge in our disconnected society is, how are we going to turn death back into something that—right along with birth, marriage, and other rites of passage—is a community event?" says Hafner. "Where do people find community in this day and age? If you can figure out the answer to the second question, then I think you can find the answer to the first." MM

Anne Welsbacher is a Minneapolis writer.

HealthPartners®

CHOICES AND CHANGES:

Simple Tools for Health Improvement

THE HEALTHPARTNERS MEDICAL COUNCIL PRESENTS ITS ANNUAL MEETING
and a special CME program on health improvement



Featuring internationally-renowned researcher and behavior change expert,

James Prochaska, PhD,

acclaimed as the top authority on using behavior change to improve health, and **Julie Abbott, MD, MPH,** Chair of the Division of Preventive & Occupational Medicine at Mayo Clinic

To receive a registration form, call the Continuing Medical Education Department at Regions Hospital, (612) 221-3992.

Saturday, December 6, 1997
Minneapolis Hilton & Towers

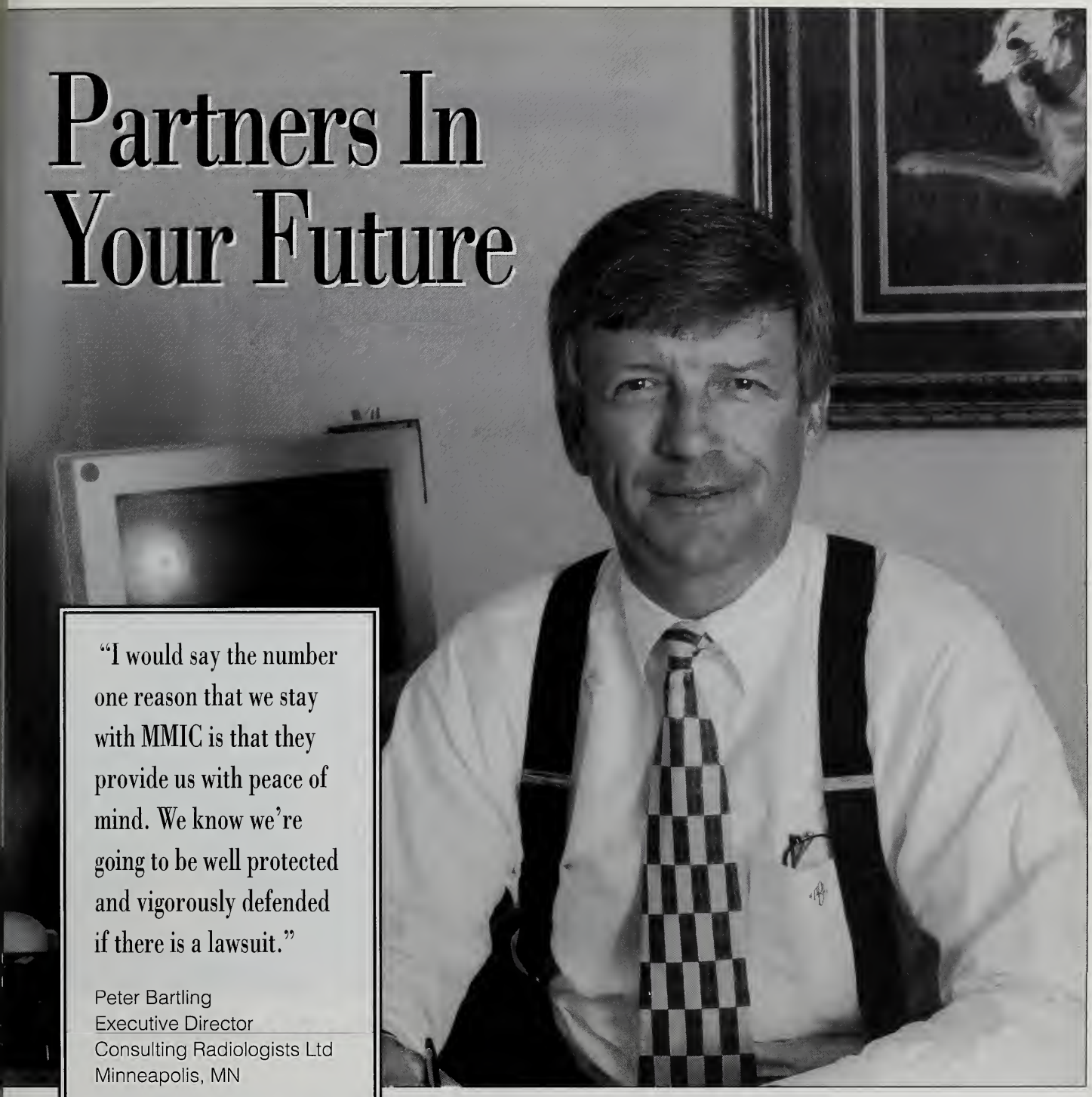
8:00 a.m. to Noon
Choices & Changes

A CME-approved educational event offered at no charge for physicians and other practitioners affiliated with HealthPartners' staff and contracted clinics

Noon to 2:30 p.m.
HealthPartners Medical Council Luncheon & Business Meeting

All physicians welcome.

Partners In Your Future



"I would say the number one reason that we stay with MMIC is that they provide us with peace of mind. We know we're going to be well protected and vigorously defended if there is a lawsuit."

Peter Bartling
Executive Director
Consulting Radiologists Ltd
Minneapolis, MN

In today's changing medical environment, physicians need to view their professional liability insurer as an important partner in their future. And what better partner can a physician have than a physician-owned and controlled liability insurer such as Midwest Medical Insurance Company. A company that understands a physician's desire to practice the art of medicine.

As your partner, MMIC is here to assist you in your new working relationships and to develop products and programs which improve patient care and lower liability exposures.

MMIC is here for the long term. We bring to the partnership a financial strength of over $251 million in assets and a total equity of over $104 million. Our rating from A.M. Best is A (EXCELLENT).

For a competitive quotation and other information on services offered by MMIC, please call us at 1-800-328-5532.

MMIC

MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S. Minneapolis, MN 55435-1891

A daughter is grateful that her father's physicians knew how far to push before letting go.

Just Over the Horizon



By Andrea Matthews

My father was an oncologist who specialized in children's cancers. When I was 11, I became a candy striper at St. Mary's Hospital (now Fairview-University Medical Center), where he practiced. Visiting his department each day over summer breaks, I watched my father pull kids in a little red wagon into the treatment rooms, joking with them along the way. I saw some children recover, watched some get worse, and waited on several occasions for those who never returned. I met girls my own age for whom treatment had failed; their families took them to Lourdes, to Mexico, to faith healers. I developed a crush on a boy who made it through less than half his treatment schedule before cancer stepped in as victor. I had fantasies of growing up and adopting a baby named Rory, whose parents had abandoned him at birth at the hospital, where he eventually succumbed to leukemia.



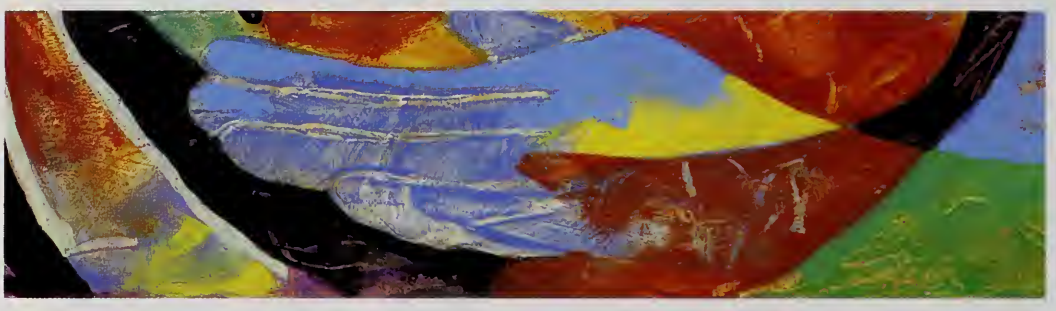
ILLUSTRATIONS BY JIM DRYDEN

My father didn't have answers to my myriad questions about this strange and powerful force, death. He would only tell me what his father told him: "Life is eternal, love is immortal, death is a horizon—and a horizon is nothing but the limit of our vision."

My first personal encounter with death came when I lost my father, this seemingly invincible man who had the ability to heal children. He was 56; I was barely 23. It was very sudden. He had a dissecting aneurysm of the aorta and was in a coma for 10 days after heart surgery. The doctors—his closest friends—reinforced our hopes. Family friends stopped by and offered pats on the back and reassurances that all would be fine.

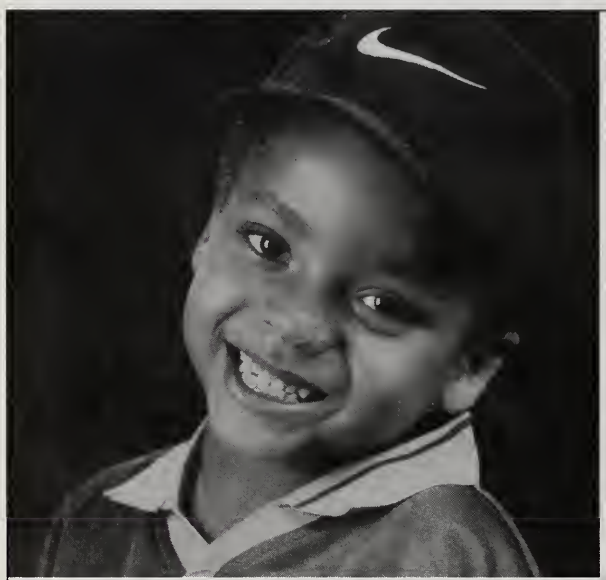
On the 11th day, my father's blood pressure dropped and doctors could not do anything to bring it back up. Tests showed that my father had sustained significant brain damage and would never wake up, though he could probably be kept in this frozen state for some time. I consulted with his doctor about stopping the medicines that were keeping him alive, if you could call it that. My father was a vibrant man. He would have hated the thought of being sustained, lifeless, in a hospital bed. It was against everything he believed in. We agreed to stop the medication. My two sisters and I stood at his bedside as my mother stood over him, clasping his hand and urging him, "Fight harder! For me. Come on! Hang in there." He did. For a number of minutes he hovered between life and death, waiting, and I was suddenly afraid that we had made the wrong decision. *continued*

Then I had a moment of incredible stillness. I remembered the doctor outlining the brain damage for me. I retraced the steps of every diagnosis, every moment where things had gone awry. I thought of the many discussions I'd had with my father about death. And I experienced a sudden surge of strength and understanding, what I've come to think of as the best parts of my father as they manifest themselves in me. I whispered to my mother, told her to tell my father it was OK to let go. When she finally said those words, my father left this world.



Losing my father before I was old enough to have really great conversations with him is tough as hell, and I think about him every day. But I'm grateful that his physicians allowed him to die with grace and dignity. I'm grateful that they knew how far to push before letting go. I'm grateful that, as I hit my mid-30s, I still have flashes of my father that seem to place him just barely beyond the periphery of my vision. And that's exactly as he had explained it to me. MM

Reprinted with permission from the Minneapolis Star Tribune, *May 26, 1997.*



For 100 years, we've been creating new stories every day about our care for kids with chronic conditions.

Since 1897...

Gillette Children's
Specialty Healthcare

An Essential Community Provider

DaShon's Story

When DaShon was struck by a car, the 5-year-old ended up with a brain injury and severely broken leg. He found the care he needed at Gillette Children's Specialty Healthcare.

Gillette Children's Pediatric Brain Injury Program has doctors, nurses and therapists who specialize in rehabilitation for children. We also have pediatric orthopaedic surgeons. All within one hospital.

With continued therapy at Gillette Children's, DaShon will soon be out of his wheelchair and back to being an active 5-year-old boy.

If you or someone you know has a child with special medical needs, call Gillette Children's.

For more information, contact Gillette Children's Specialty Healthcare: (612) 229-3851.

- Cerebral palsy and other neuromotor delays
- Brain and spinal cord injuries
- Complex orthopaedic conditions
- Spina bifida
- Juvenile arthritis
- Epilepsy
- Chronic pain
- Technology dependency (children who breathe on ventilators)

Affiliated
COMMUNITY
Medical Centers, P.A.

Join the security of a large multispecialty group located in Southwest and West Central Minnesota Communities of 3,700 to 19,000. All areas flourish with four-season recreational opportunities, strong economies and excellent education where family and lifestyle are a priority. Outstanding benefits for BE/BC physicians in:

Dermatology	Neurology
Family Practice	Ob-Gyn
Internal Medicine	Orthopedic Surgery

Contact: Janiece Durham
Physician Recruitment Coordinator
Affiliated Community Medical Centers
101 Willmar Avenue SW
Willmar, Minnesota 56201-3591
320-231-6366

Wilderness Charm and Cosmopolitan Amenities

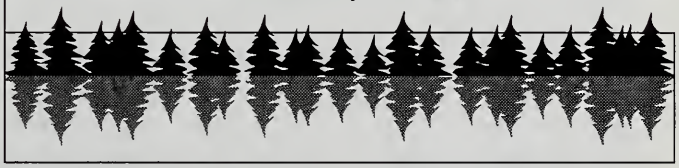
St. Mary's/Duluth Clinic Health System, a 300-physician multi-specialty group, with 3 hospitals and 22 neighborhood & regional centers serving a referral population of 460,000, seeks physicians in the following areas:

EP Cardiology	**Neurology**
Cardiothoracic Surgery	**Ophthalmology**
Dermatology	**Ortho Surgery – Hand**
Emergency Medicine	**Pediatrics**
Family Practice	**Psychiatry – Adult**
Internal Medicine	**Psychiatry – Child**
Nephrology	**Radiology – Invasive**
	Rheumatology

We offer a complete compensation package, including excellent fringe benefits and generous vacation/CME time. Only here can you listen to a duet of loons and a symphony orchestra in the same evening.
(Sorry, no J-1 waiver opportunites.)

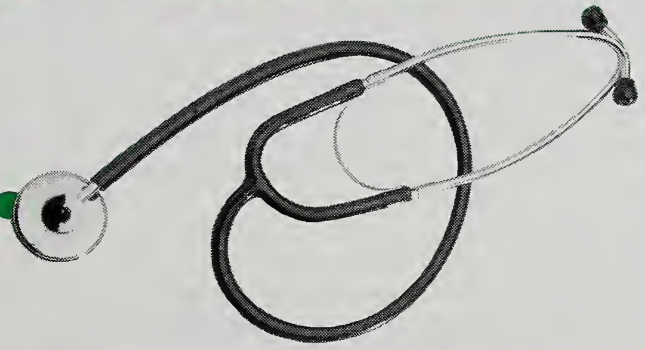
Contact Mike Griffin Marci Jackson or Jocelyn Heid,
SMDC, 400 E. 3rd St., #500, Duluth, MN 55805
or call 1-800-342-1388 or fax 218-722-9952
or e-mail to: sr@smdc.org

SMDC
St. Mary's/Duluth Clinic Health System *eoe*



www.startribune.com/workavenue

MAKE YOUR ROUNDS ON NEW GROUNDS.





Put your resume on WorkAvenue.com. It's a free, Star Tribune Internet Web site that automatically matches job openings with resumes from people in the health field and other industries. It's free, easy and confidential.* So go to the site. Because we make finding a new job painless.

If you don't have Internet access, send your resume to WorkAvenue.com, Star Tribune, P.O. Box 1617, Mpls., MN 55440-1617. It'll be electronically scanned and placed in the Workavenue.com database. For best results, call 612-673-9012 first.
*The confidentiality feature is only available when you enter your resume on-line.

www.startribune.com/workavenue

Star Tribune
It's where you live.

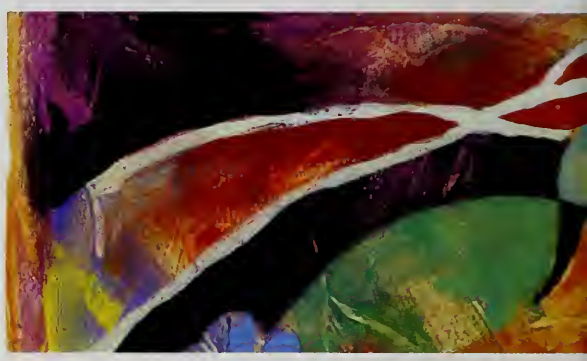
370073R/7/97

HOSPICE

An Alternative to Needless Suffering or Suicide

Absent from the debate over physician-assisted suicide is an option that provides physical, emotional, and spiritual relief for the dying.

By Matt Malloy



"In the attempt to defeat death, man has been inevitably obliged to defeat life, for the two are inextricably related. Life moves on to death, and to deny one is to deny the other."

–Henry Miller

Throughout history, writers and artists pondered and portrayed death and dying—one of the most enduring themes in studies of the human condition. Ironically, we now find ourselves gripped in a national debate about physician-assisted suicide—a debate that might not be necessary if we were more open, honest, and knowledgeable about the dying process.

Absent from this debate is information about a readily available, medically sound program for providing adequate pain control and relief to terminally ill patients and their families. This program has existed in the United States for more than 20 years but dates back to earlier times when families and communities administered care to the dying. The program is hospice—one of the best-kept secrets in health care today.

Fueling the Debate

"It is impossible that anything so natural, so necessary and so universal as death should ever have been designed by Providence as an evil to mankind."

–Jonathan Swift

Last June the Supreme Court unanimously ruled that terminally ill people do not have a constitutional right to physician-assisted suicide. In the court's decision, Chief Justice William Rehnquist said allowing someone to help end another person's life conflicts with "our nation's history, legal traditions, and practices."

While these words ring true to opponents of physician-assisted suicide, our society is far from unanimous agreement on this thorny issue. How else can one explain Dr. Jack Kevorkian? The retired pathologist and his rusted-out van have become symbols for the right-to-die movement. While "Dr. Jack" has initiated much-needed public discussion about end-of-life care, his increasingly irresponsible acts epitomize the "slippery slope" that many people feel makes physician-assisted suicide indefensible.

Because the media tend to focus on extremes, we often see only two choices: prolonging life despite excruciating pain or choosing to end life to avoid such suffering. Unfortunately, not all options are being discussed. Almost completely overlooked are the palliative care services provided through hospice programs.

The Argument for Hospice

"Dying is a troublesome business; there is pain to be suffered and it wrings one's heart; but death is a splendid thing—a warfare accomplished, a beginning all over again, a triumph. You can always see that in their faces."

–George Bernard Shaw

Across the country last year, 450,000 terminally ill individuals and their families—including nearly 10,000 in Minnesota—were cared for by hospice programs. Yet

HOSPICE continued on page 59

PAIN RELIEF

Legal Aspects of Pain Relief for the Dying



ILLUSTRATION BY JIM DRYDEN

Fear of legal repercussions should not deter physicians from doing everything in their power to relieve pain in dying patients.

By Phebe Saunders Haugen, J.D.

"If the changes we fear be thus irresistible, what remains but to acquiesce with silence, as in the other insurmountable distresses of humanity? It remains that we retard what we cannot repel, that we palliate what we cannot cure."

–Samuel Johnson,
A Dictionary of the
English Language (1755)

For more than seven years, notorious pathologist Jack Kevorkian has defied the American legal system to find him guilty of a crime. More than 45 people have ended their lives with his assistance, yet three juries have acquitted him of the crime of assisting suicide, and prosecuting authorities in his home state of Michigan seem resigned that they are unlikely to convict this very public and unsavory man.[1]

Public support for assisted suicide seems strong; surveys reveal that as many as two-thirds of Americans support some form of medically assisted death.[2] Research also shows, however, that when people are presented with another option—compassionate hospice care and, especially, good pain control for the dying—only 13 percent say they would still choose physician-assisted suicide.[3]

Earlier this year, the United States Supreme Court, in overturning two circuit court decisions, held that Americans have no fundamental right to assistance in suicide, and that equal protection of the law is not denied to those who could hasten their death only with the active assistance of another person.[4,5] In so doing, the high court left intact criminal statutes in New York and Washington that, like a similar statute in Minnesota, prohibit assisted suicide. The court encouraged continued societal debate about physician-assisted suicide, and effectively left it to the states to experiment with legislation that would make the practice legal. So far, only Oregon has done so, in a law passed by the narrowest of margins and currently suspended by legal challenges.[6]

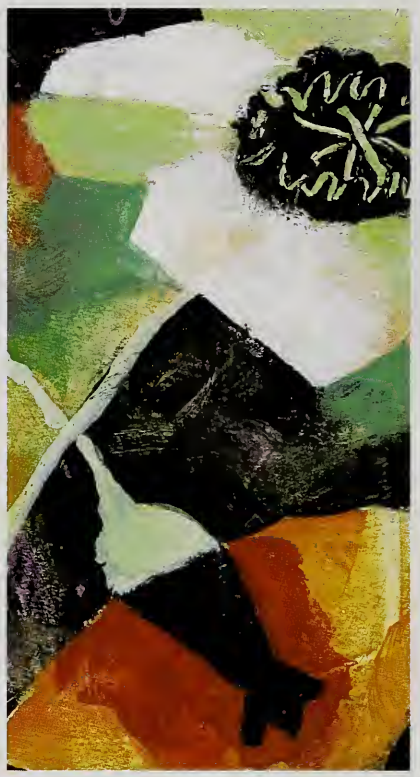
Why does this subject, older than Hippocrates, still engage us? Why do so many of us insist that we be allowed to end our lives prematurely, and that physicians be allowed to help us? The answers to these questions are complex and multifaceted. Anyone who thinks the issue comes down to simply patients' legal rights or physicians' sacred duty to "do no harm" underestimates the depth of the problem. Still, it is fair to say that inadequate care of the dying accounts in large part for our fear of dying.

Humane, compassionate, and effective care for the dying, including good pain control, is provided only irregularly in this country, despite the efforts of numerous professional organizations to stress its critical importance. Fearing dependency, loss of control, overuse of medical technology, and, especially, unrelieved pain, patients and their families have resorted to desperate measures. In one survey, 69 percent of cancer patients said they would consider committing suicide if their pain were not treated adequately.[7] The widely reported SUPPORT study (Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatments) found that two-thirds of patients with advanced cancer report pain.[8]

Other studies indicate that as many as 95 percent of these patients *can* get good pain relief if skilled practitioners administer the right medications in the right ways.[9,10]

Barriers to Pain Relief

While dying patients' needs are complex and cannot be met by physicians alone, good medical care can do much to improve this picture. Patients whose physical suffering is adequately controlled rarely want to commit suicide.[9] Certainly, then, our task should begin with removing any barriers to effective pain control for dying patients.



Many factors contribute to the problem of inadequate end-of-life care. While palliative medicine has finally been endorsed as a critical part of any health care policy, and hospice medicine has flourished in the United States, hospices serve only 17 percent of dying patients.[11] Medical schools still offer little training in palliative care, and most medical residents receive minimal education in caring for the terminally ill.[12,13] Despite the availability of guidelines for the aggressive management of intractable symptoms in dying patients,[14-16] health care professionals' knowledge of pharmacology and pain management is sorely deficient in this country.[17-21] Misunderstanding about the normal development of tolerance to opioids and unfounded fears of addiction still persist among patients and physicians alike.[7,22-25]

Perhaps the greatest barrier to good pain control, however, is the fear of legal sanctions against the provider who gives the last dose of narcotics to a dying patient. In Minnesota, this fear was heightened in 1989, when the Hennepin County Medical Examiner investigated physicians in two area hospitals for their care of two dying, ventilator-dependent patients whose deaths followed the withdrawal of breathing support and the administration of relatively large doses of morphine to ease their suffering. Fortunately, the county attorney examined the cases and relevant principles of law and medical ethics in a thoughtful (though maddeningly protracted) manner, and ultimately he declined to bring the cases to the grand jury for prosecution.[26,27] Still, the investigations provoked considerable distress in the medical community, and in most metropolitan hospitals and even some hospices, dying patients were inadequately medicated for pain because of their medical caregivers' fear of "causing death" and facing criminal sanctions.

These investigations, though not unprecedented, were extremely unusual, and they ended without legal action of any sort. Nevertheless, fear of legal sanctions for hastening a patient's death continues to be the main reason many doctors and nurses believe that "the most common form of 'narcotic abuse' in the care of the dying is undertreatment of pain."[20] These fears of legal liability are greatly exaggerated, and they must be dispelled if the goal of fully effective pain control for all dying persons is to be realized.

Fears of Legal Sanction Are Unfounded

No physician in the United States has ever been convicted of murder or assisted suicide for providing a patient with high doses of medication for pain relief.[17] Indeed, no physician has ever lost a civil case or been criminally convicted for withholding or withdrawing treatment from a terminally ill patient, nor has any physician been successfully prosecuted even for a direct act of euthanasia.[28] Lawsuits, criminal investigations, and professional licensure review can cause anguish and disrupt a physician's life and practice. Nevertheless, good medical practice—which compels aggressive treatment of pain in all suffering patients—is given great deference by the law, which will protect a physician's best judgment in virtually every case. Only in exceedingly rare instances of outrageous conduct by physicians—conduct that far exceeds anything that could be regarded as good faith medical judgment—has criminal law seen fit to intervene, or has civil liability been attached.

University of Maryland Baltimore

None of those cases involved pain relief for dying patients.[28,29]

Every day, physicians are called upon to weigh the potential benefits of a treatment intervention against its potential for harm. Decisions to use powerful drugs to fight cancer, for instance, are always made with an awareness of the unavoidable side effects, which may hasten or even cause the patient's death. Risky surgery requires consideration of the possibility that it may kill the patient if it does not cure him or her. When prescribing heavy-artillery narcotics to a person suffering the excruciating pain of some terminal illnesses, most physicians understand that side effects such as respiratory depression may hasten the patient's death. These interventions are protected by the ethical principle of double effect: when the need is great and the intent is to bring about a good effect, it is worth taking the risk that a bad effect may be unavoidable. This is a principle of law as well. Intent is crucial. A death that follows aggressive efforts intended to secure pain control—no matter how swiftly that death occurs—is neither euthanasia nor assisted suicide under the law. Physicians should not fear legal repercussions for using all the tools at their disposal to keep dying patients as free from pain as possible.

Guidelines Help Clarify the Issue

Since the morphine investigations, a number of significant developments have occurred that should make it easier for physicians to provide good pain relief to patients in these difficult end-of-life situations.

During the 1989 investigation, it became apparent that in both cases the need for morphine at the levels given was not adequately documented. It was also clear that most health care institutions had no formal procedures or guidelines to assist physicians in prescribing the appropriate use of large dosages of pain-relieving medication. To bring some clarity to the issue and guidance to physicians, the Hennepin County Medical Society prepared the "Position Paper on Management of Pain and Suffering in the Dying Patient," supported by a wide consensus of the Minnesota medical community.[30]

Shortly thereafter, the Hennepin County attorney and the medical examiner issued a statement calling on medical institutions to formulate guidelines for the administration of pain-relieving drugs. The statement urged health care centers to revise their policies to reflect the concerns raised in the morphine cases (particularly about documentation), and to give better, more specific guidance to doctors who must decide how best to dispense high dosages of narcotics to their dying patients.

Although the medical community initially did not react favorably to that report, constructive dialogue between representatives of the Minnesota Medical Association and Hennepin County officials followed. A number of hospitals began to take steps to adopt guidelines and policies related to the delivery of well-documented, effective pain control to terminally ill patients. According to the county attorney, "compliance with the guidelines [would] be overwhelming evidence that the physician not only acted in good faith, but also that the administration of the pain-relieving drug was done in a manner consistent with prevailing medical standards. In such circumstances, there can be no criminal liability."[26,27,31]

In 1992, the Minnesota statute prohibiting assisted suicide was amended to add a subdivision stating that a "health care provider ... who administers, prescribes, or dispenses medications or procedures to relieve another person's pain or discomfort, even if the medication or procedure may hasten or increase the risk of death, does not violate this section unless the medications or procedures are knowingly administered, prescribed, or dispensed to cause death."[32]

Other states have passed similar provisions in an effort to assure doctors that they will not face criminal charges for providing appropriate and compassionate palliative care for dying patients.[33-36]

On the national level, the Health Care Financing Administration has approved a new diagnosis code for palliative care, which should eventually allow for payment of palliative care expenses for hospitalized patients as they approach death.[11] Additionally, at least 47 states have launched initiatives to increase awareness and knowledge about effective palliative care strategies.

The prospect of legal access to physician-assisted suicide raises disturbing questions about our society's commitment to compassionate care of the dying. Of the many articulate and persuasive challenges to physician-assisted suicide, one of the most compelling concerns is that if we permit the practice, we will no longer work vigorously and creatively to make dying more comfortable, more peaceful, and more meaningful for the vast majority of patients who do not want to resort to suicide. Physicians should take heart that the law will support them in their efforts "to comfort always," as they seek to observe the ancient Hippocratic command, "[t]o please no one will I

prescribe a deadly drug, nor give advice which may cause his death."[37]

Kathleen M. Foley, who has written extensively about palliative care for the dying, explains how she responds to the challenge of helping patients who are suffering:

"How then ... do I respond to patients' requests for physician-assisted suicide? In the only way I can, by saying that I value their lives and their worth and therefore cannot kill them. I tell them, too, that I will care for them and treat their symptoms, and, if their pain cannot be adequately controlled while they are dying, that I will honor their choice to be sedated. And, last, I assure them that I will never abandon them but will remain to the end a witness to their dying."[38] MM

Phebe Saunders Haugen is a professor of law at William Mitchell College of Law in St. Paul, Minnesota.

REFERENCES

1. Prosecutor drops charges against Kevorkian. Chicago Tribune 1997 January 11:11(News).
2. Bachman JG, Alcser KH, Doukas DJ, Lichtenstein RL, Corning AD, Brody H. Attitudes of Michigan physicians and the public toward legalizing physician-assisted suicide and voluntary euthanasia. N Engl J Med 1996;334:303-9.
3. AMA poll: the more patients know, the less they want suicide aid. Am Med News 1997 January 13:3.
4. Washington v. Glucksberg, __US__,117 S.Ct. 2258, 138 L.Ed. 2d 772 (June 26, 1997).
5. Vacco v. Quill, __US__, 117 S.Ct. 2293, 138 L.Ed. 2d 834 (June 26, 1997).
6. Act of Nov. 8, 1994, Ch. 3, 1995 Or. Laws (ballot measure 16).
7. Foley KM. Misconceptions and controversies regarding the use of opioids in cancer pain. Anticancer Drugs 1995;6:4-13.
8. The SUPPORT Principle Investigators. A controlled trial to improve care for seriously ill hospitalized patients: the study to understand prognoses and preferences for outcomes and risks of treatments. JAMA 1995;274:1591-8.
9. Foley KM. Controlling the pain of cancer. Sci Am 1996 September:164-5.
10. Saunders CM. Current views on pain relief and terminal care. In: Swerdlow M, ed. The therapy of pain. Lancaster, England: MTP Press, 1981:215-41.
11. Cassel, CK, Vladeck BC. ICD-9 code for palliative or terminal care. N Engl J Med 1996;335:1232-4.
12. Hill TP. Treating the dying patient: the challenge for medical education. Arch Intern Med 1995;155:1265-9.
13. Foley KM. Competent care for the dying instead of physician-assisted suicide. N Engl J Med 1997;336:54-8.
14. Cherny NI, Coyle N, Foley KM. Guidelines in the care of the dying patient. Hematol Oncol Clin North Am 1996;10:261-86.
15. Cherny NI, Portenoy RK. Sedation in the management of refractory symptoms: guidelines for evaluation and treatment. J Palliat Med 1994;10:31-8.
16. Truog RD, Berde CB, Mitchell C, Grier HE. Barbiturates in the care of the terminally ill. N Engl J Med 1992;327:1678-82.
17. Buchan ML, Tolle SW. Pain relief for dying persons: dealing with physicians' fears and concerns. J Clin Ethics 1995;6:53-61.
18. Cleeland CS. Pain control: public and physician attitudes. In: Hill CS, Fields WS, eds. Advances in pain research and therapy. Vol. 11. New York: Raven Press, 1989:81-9.
19. Ferrell B, McGuire DB, Donovan MI. Knowledge and beliefs regarding pain in a sample of nursing faculty. J Prof Nurs 1993; 9:79-88.
20. Solomon M, O'Donnell L, Jenning B, et al. Decisions near the end of life: professional views on life sustaining treatments. Am J Public Health 1993;83:14-23.
21. Von Roenn JH, Cleeland CS, Gonin R, Harfield A, Pandya KJ. Physician attitudes and practice in cancer pain management: a survey from the Eastern Cooperative Oncology Group. Ann Intern Med 1993;119:121-6.
22. Foley KM. Pain relief into practice: rhetoric without reform. J Clin Oncol 1995;13:2149-51.
23. Tuttle B. Drug management of pain in cancer patients. Can Med Assoc J 1985;132:121-32.
24. Lo B, Coleman R. Exceptionally high narcotic analgesic requirements in a terminally ill cancer patient. Clin Pharm 1986;5: 828-32.
25. Foley KM. The treatment of cancer pain. N Engl J Med 1985;313:84-95.
26. Feldman MK. Pain control in dying patients: how much is too much? Minn Med 1990;73:19-24.
27. Johnson T. Good death can have a bad ending. Hennepin Lawyer 1991;60:10-11.
28. Glantz L. Withholding and withdrawing treatment: the role of the criminal law. Law Med Health Care 1987;15:231-41.
29. Annas GJ. Medicine, death and the criminal law. N Engl J Med 1995;333:527-30.
30. Hennepin County Medical Society. Hennepin County Medical Society position paper on management and pain of suffering in the dying patient. Minn Med 1990;73:36-7.
31. Carlson JP. Managing pain and suffering in the dying patient. Minn Med 1990;73:35-7.
32. Minn. Stat. § 609.215, subd. 3(a) (1996).
33. Colo. Rev. Stat. § 18-3-104 (Supp. 1996).
34. Ind. Code Ann. § 35-42-1-2.5 (Supp. 1996).
35. Tenn. Code Ann. § 39-13-216 (Supp. 1996).
36. Utah Code Ann. § 75-2-1116 (1993).
37. Walton J, Barondess J, Lock S. Oxford medical companion. New York: Oxford University Press, 1994:371.
38. Foley KM. Pain and America's culture of death. Wilson Quarterly 1994 Autumn:20-1.

University of Maryland Baltimore

150 years of caring for the country 1847-1997

Make a commitment to your patients and your profession.
Join or renew your membership in the AMA today.

American Medical Association

Physicians dedicated to the health of America



Bringing Bioethics Theory *to the* Bedside



ILLUSTRATION BY RUSS MCMULLIN

Ethics committees shed light on the murk of uncertainty surrounding end-of-life decision-making.

By Howard Bell

Hospital ethics committees confront a question with no right or wrong answer: Just because we can, should we? Their importance has grown as technology outstrips a physician's ability to decide what to do with that technology. When is it right to withdraw or withhold treatment? What happens when a physician is uncomfortable with a family's wishes? Ethics committees shed light on the murk of uncertainty related to defining futile treatments, using emerging technologies, and handling requests to start or stop therapy. They bring doctors, families, and patients to the same table to clarify issues and desires.

University of Maryland Baltimore

Most Minnesota hospitals have ethics committees; Hennepin County Medical Center created the nation's first in 1971, and the concept has since spread across the country. These committees arose naturally out of Minnesota's culture of consensus and collegiality, according to Ron Cranford, M.D., a Hennepin County Medical Center (HCMC) neurologist who chairs the Minnesota Medical Association's Committee on Ethics and Medical-Legal Affairs. "These are non-adversarial committees that evolved naturally out of our non-adversarial culture."

And Minnesota may once again be leading the nation with the creation of community-based ethics committees. A well-established ethics committee in the Stillwater area, for example, represents a variety of institutions throughout the St. Croix Valley, allowing continuity of care between hospitals, long-term care institutions, and home care agencies. Meanwhile, a brand of ethics called organizational or system ethics is emerging out of vertically integrated health care systems to address conflicts posed by managed care's focus on cost control.

Reaching Consensus

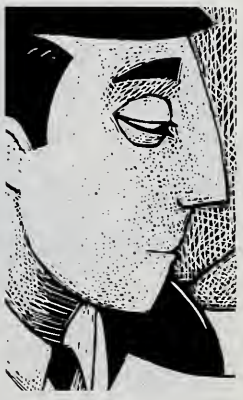
Ethics issues are a broth of clinical fact, subjective opinion, and personal values, and ethics committees stir and clarify the broth with various thinking tools. Committees use methods such as the "goal of substituted judgment" (what would the patient want?). They assess the burdens of intervention and measure the strength of objections to withholding or continuing care.

"Some issues like brain death are defined with clinical parameters," says Dianne Bartels, associate director of the University of Minnesota Center for Bioethics. "Others, like futility and quality of life, are subjective, so values get mixed in with clinical parameters."

The goal is to reach consensus on a course of action. If that is not possible and the physician is uncomfortable with the family's wishes, another physician may be assigned to the patient.

St. Luke's Hospital Ethics Committee in Duluth is typical of how hospital ethics committees operate. The 12-member committee includes physicians, critical care nurses, social workers, mental health counselors, clergy, and hospital administrators. The committee consults primarily with doctors and families on end-of-life care decisions like organ donations and withdrawal or withholding of care. It formulates policy and decision-making guidelines and educates patients, families, and hospital staff about legal precedents, care options, advance directives, and decision-making rights. A committee member is "on call" at all times and can convene a special meeting to address dilemmas requiring immediate attention.

The ethics committee reviews cases at its monthly meetings not only to educate committee members, but also to assure consistency and quality control. It also reviews the latest bioethics literature. By doing so, committee members serve as a conduit for transferring bioethics theory and research to the bedside. The committee's annual ethics education day usually fills the hospital auditorium with staff and the public. This year's topic: whether the growing need for organ donors will force change in how death is defined.



Making a Difference

Even if ethics committees did nothing but educate, their contribution to medicine would be enormous, according to Cranford. "Ethics committees serve as great bedside educators. They translate broad ethical themes into bedside concepts. To a great extent, we've reached consensus on euthanasia and DNR [do not resuscitate] guidelines. Stopping treatment is no longer a big issue. Nutrition and hydration are still big issues, but a couple landmark cases established that it's legal and ethical to pull feeding tubes. Brain death cases are now routine. Doctors feel safe pronouncing a patient brain dead. Committees have helped doctors, patients, and families become smarter about options and rights."

Ethics committees can also protect patients and their families from public scrutiny, according to Karen Gervais, Ph.D., ethicist and director of the Minnesota Center for Health Care Ethics. "Without ethics committees, private family decisions can become public. Conflict spills into the community. There's potential for media involvement. The family's right to make decisions is compromised," says Gervais, who offers outside consultation to ethics committees unable to resolve a dilemma and to health care facilities that don't have an ethics committee to referee the decision-making.

Protecting Hospitals from Litigation

Ethics committees also have a role in protecting hospitals, says Julian Zwebar, J.D., a Minneapolis attorney who specializes in elder law. "We can talk about altruism," he says, "but there are financial reasons for

hospital ethics committees, too. They protect hospitals and doctors from litigation."

The University of Minnesota's Bartels agrees. "I don't have the numbers," she says, "but I can tell you these committees have helped hospitals avoid lots of litigation by eliminating much of the fear and confusion that surrounds end-of-life decisions."

Tension between law and bioethics is a fact of life, according to Cranford, but the tension has lessened, thanks in part to hospital ethics committees. "Committees apply decision-making methods that involve families and patients, and they help educate the public about advance directives, all of which help minimize legal liabilities," Cranford says. "Less and less do we find legal liability the primary reason for stopping or continuing treatment."



That doesn't mean litigation isn't good for bioethics, Cranford adds. "It's part of the engine that drives society forward. One landmark case can educate us so much that future such cases don't require litigation."

Educating through Consultations

To spread the insights they have acquired, some established ethics committees offer consultation services in their hospitals. Most often, it's physicians on staff who request a consultation. Ultimately, families and sometimes patients are included. HCMC's ethics committee does one or two formal consults each month. It receives informal requests for information daily. The Mayo Foundation Ethics Committee has an Ethics Consultation Service that handles 40 to 50 requests a year, according to Christopher Hook, M.D., a Mayo hematologist who chairs the service. Typically, about 15 requests require formal consultation.

Most committees use some type of case consultation model—a fact-gathering sheet and a series of questions or steps to structure the consultation. Committees are advisory only. They view themselves not as

An Ethics Consult

Hospital ethics committees help negotiate a consensus between families and caregivers when the two parties disagree about withholding or withdrawing treatment. The following situation recently occurred at a Minnesota hospital.

A 72-year-old man who had undergone coronary bypass surgery but still had complete heart block and a permanent pacemaker presented at the hospital emergency department with a massive myocardial infarction. He coded, failed to regain consciousness, and was left with an ejection fraction of 8 percent.

The patient's family asked that no aggressive therapies be given and requested that the patient's pacemaker be shut off. The attending physician agreed to withhold aggressive therapies but resisted the family's request to deprogram the pacemaker, which would most certainly cause immediate death. The physician felt the family's request crossed the line into euthanasia. The patient had a living will stating he did not want to be "artificially sustained."

The family requested an ethics consultation and was put in touch with the hospital ethics committee member on call, who concluded there was no legal reason for not conforming to the family's request. The physician, however, was still uncomfortable with the request.

The on-call ethics committee member then interviewed the caregivers and the family and examined the patient's advance directive and medical record. The on-call member then began a formal consultation process by convening an interdisciplinary working subcommittee that included a physician, critical care nurse, attorney, chaplain, and social worker.

The subcommittee interviewed the family and physician separately, then mediated a discussion with both parties present. The ethics committee concluded that the family's request to discontinue the pacemaker was ethically acceptable, similar to discontinuing ventilator therapy, dialysis, or any other artificial life-sustaining therapy. It was also in keeping with the consensus of the larger bioethics community and important legal precedents, such as the Cruzan decision. The subcommittee did not

decision-makers but as facilitators for those who must make end-of-life care decisions.

No matter what framework a committee uses, the objective is the same: organize the facts in a manner that can be understood and analyzed and provide a forum in which all parties involved have a say. Hook recalls entering a room where a consultation had commenced. "I was listening to everyone talk. There was so much confusion, disagreement, and wheel-spinning. Once we asked the right questions and applied our process, every single person in the room agreed on what the priority issues were."

Ironically, the more successful committees are in educating, the less their services are needed. "This reflects the confidence physicians and families have in making decisions," says David Camenga, M.D., a Duluth Clinic neurologist and chair of the St. Luke's ethics committee.

The ethics committees at HCMC, Mayo, and St. Luke's have all experienced declines in consultation requests. "Everyone's more aware of what the options are," says Camenga. "Death and dying are more openly discussed in our society now, too. Families and physicians know about advance directives. We're seeing less conflict between families and doctors. We've evolved a social consensus."

"It almost hurts your feelings [not to get calls]," says Cranford, "but the better job a committee does in educating, the fewer calls it gets."

Hospital ethics committees may be good at their job, but they're still learning. "Committees are getting better at incorporating family wishes," says Cranford, "but we need to pay more attention to what effect decisions have on the family. It's the family that lives with the decision—financially and psychologically."



Defining Futility

Ethics committees deal in feelings and values, but bioethics as an academic discipline attempts to design guidelines and decision-making models to spell out options and reach consistent decisions. With funding from the

consider shutting off the pacemaker an act of euthanasia and encouraged the physician to carry out the family's wishes. Despite this analysis, the attending physician did not believe it was ethical to discontinue the pacemaker. Wishing to respect the views and ethical interests of both parties, the subcommittee arranged to transfer care of the patient to a physician not morally opposed to the family's wishes. The pacemaker was discontinued and the patient died.

Two hypothetical twists to the actual case further illustrate how the ethics committee would function.

Scenario 1

The patient does not have a living will, so the family serves as proxy or surrogate for the patient. The subcommittee would attempt to determine the patient's wishes by interviewing the family. "Did he ever say anything about his wishes concerning end-of-life medical care? What do you think he would have said?" If the family members agree, their wishes will be taken as the patient's wishes.

If the family is uncertain or disagrees about what the patient would want, the subcommittee would negotiate a consensus to end care based on "what the vast majority of rational common people would want in this situation." The goal would be to ascertain the patient's best interests. The case for discontinuing the pacemaker is weaker, but the subcommittee would still attempt to negotiate a con-sensus to discontinue the pacemaker, which the subcommittee considered no different from discontinuing a ventilator or dialysis.

Scenario 2

The family wants the pacemaker stopped, but the attending physician and the ethics committee feel there's a reasonable chance for a recovery that the patient would find satisfactory, based on his values. The subcommittee would attempt to negotiate consensus on a reasonable length of time that care would be continued to allow improvement, but not so long as to maintain the patient in a state that the parties feel would be unacceptable to him.

–HB

Allina Foundation, the Minnesota Center for Health Care Ethics is crafting guidelines to help prevent or handle conflicts that arise over futile treatment. Initially, project participants attempted to define futility. It didn't work. Representatives from 38 of Minnesota's largest health care facilities could not agree on a definition.

"We dismissed it as unworkable," says Dorothy Vawter, Ph.D., the center's associate director and coordinator of the futility project. "We found there were many more reasons than expected for why physicians refuse to comply with intervention requests. Definitions are either too narrow to be useful or too broad to be appropriate." Still, the center's attempt to define futility yielded good information for crafting guidelines that help physicians respond to a patient's or family's request for an intervention the physician feels is inappropriate.



Project participants weighted the reasons for withholding or withdrawing care based on degree of consensus. They are developing a similar list for the patient and family perspective. Vawter finds these weighted lists useful when doing ethics consultations. With a little more refinement of the lists, she believes, ethics committees will find them useful, too. "Will physicians carry these lists, grids, and models around with them? Maybe not," says Vawter. "But 87 percent of institutions participating said model futility guidelines would be useful."

The center's emerging futility guidelines offer concrete language for articulating reasons for withdrawing or withholding requested interventions. They improve communication and help avoid conflict. "It's a real conversation stopper to tell a family member something is not 'medically appropriate,' " says Vawter. "It's better to say, 'I'm not going to do this because, not only will it not work, it would cause serious harm and would be cruel.' "

Community Ethics Committees

Hospitals pioneered institutional ethics committees, but in years to come, some of the focus will shift to ethics committees that represent entire communities and health care systems.

The future of bioethics arrived in the St. Croix Valley many years ago when 12 Stillwater-area health care institutions and agencies formed the St. Croix Valley Health Care Providers Ethics Advisory Committee in 1988. Members represent area hospitals, clinics, long-term care facilities, home care agencies, and county social service and health departments. "We've largely replaced hospital-based ethics committees," says Chaplain Alan Hagstrom, who chairs the committee and directs the St. Croix Valley Chaplaincy Association. "Ethics consultations still occur at local hospitals, but not through a formal hospital ethics committee."

Like a hospital committee, St. Croix's multi-institutional committee reviews cases at monthly meetings, discusses options, solves problems, and educates. But it discusses ethical issues at all levels of care in all settings. Recent cases addressed a non-compliant home care patient and a family with strong feelings about morphine use for pain. One month members might review a home care case; the next month a long-term care or acute care case. The idea, according to Hagstrom, is to improve continuity of care and avoid duplication by assembling all levels of care and arriving at a community consensus.

"We look at what the patient or resident experiences at all provider levels," says Hagstrom. "We've prevented patient care details from slipping through the cracks because one facility thought another facility was handling it. We've avoided duplication in which two or three case managers are working with the same patient but don't know it."

Such cross-institutional ethics committees are the wave of the future, according to Cranford, partly because they're better able to smooth out the often conflicting values and approaches patients experience as they move through the system. Right now there's little continuity of care, says Cranford. For example, decisions might be based on what a long-term care facility wants, which may be very different from what the hospital wants.

Duluth's ECHO Project is creating its own version of a community-based ethics committee. Educating the Community About Health Care Options is a 75-member group that represents hospitals, long-term care facilities, ambulance services, the University of Minnesota–Duluth School of Medicine, and Duluth area residents. One of its goals is to develop ethical decision-making guidelines that reflect community values, according to Barbara Elliott, Ph.D., who chairs the ECHO Project. Elliott also chairs Miller-Dwan Medical Center's Ethics Committee in Duluth.

As associate professor in the UMD Department of Family Medicine, Elliott coordinates all ethics education for the medical school. "Bioethics tends to become medicalized," she says. "It's not about whether to hang the dopamine. It's about values held by the

people our institutions serve. We're looking at the horizon, not the trees."

ECHO is in the midst of a multiyear effort to collect information from the community about ethical issues and concerns. Subcommittees address specific issues in long-term care, adult care, and neonatology. They're producing a video, to be ready in early 1998, that will stimulate public thought using vignettes illustrating specific ethical dilemmas in long-term care, organ donation, and neonatology.

ECHO members hope hospital ethics committees will use the insights ECHO gleans from the community. ECHO also expects to arrange ethics consultations for long-term care facilities that don't have ethics committees. And they plan to review community do-not-resuscitate patterns and make the results available to all institutions in hopes the data will encourage a more uniform approach to DNR orders among Duluth area facilities.

System Ethics

Bioethic's future is also shifting to committees that shape guidelines for entire vertically integrated managed care systems. This so-called organizational or system ethics addresses managed care—"the new ethical dilemma."

The goal is to settle the ethical conflicts inherent in a delivery structure some say is better at managing cash than care. "We're struggling with ways to make system delivery structures ethically competent," says Gervais.

System ethics committees will look at some of the same issues hospital committees consider: futility, emerging technologies, genetic research, and requests for assisted suicide. But they'll build ethical frameworks that reflect a new blend of ethical priorities. System ethics committees will combine traditional patient-centered ideals, which emphasize freedom of choice, with population-centered frameworks, which factor in limited financial resources. Access, choice, and quality will be balanced against fairness, benefits, and cost.

System ethics comes down to balancing what's best for the plan with what's best for patients, according to Cranford. "We need a process that demonstrates stopping treatment for a person with end-stage Alzheimer's disease is the right thing to do for the family, not just the right thing to do for the plan's bottom line."

System ethics is brand-new. "Most people don't even know what you mean by an organizational ethics committee," says Cranford. "What few efforts are occurring nationally are mostly a public relations façade to gloss a system's image. With system ethics, we're where we were 20 or 30 years ago with hospital ethics."

The Minnesota Center for Health Care Ethics is compiling a book of managed care ethics cases—22 "incredible cases," according to Gervais, illustrating dilemmas that arise when rationing and cost controls conflict with what's best for an individual patient. The casebook will be ready for distribution next July, after 40 national experts from various perspectives contribute medical, ethical, and administrative opinions on each case. The casebook will serve as a discussion tool to address tough questions:



- Which method of structuring physician incentives is ethically most defensible?
- What are ethically appropriate ways to structure care and reimbursement policies?
- How does a system decide if unproven interventions will be covered?
- Should a managed care organization sell whatever coverage an employer wants to buy or should there be minimum standards?
- What roles, if any, traditionally assigned to physicians can be appropriately transferred to other health professionals?

Creating ethics committees for entire health care systems will be immensely complex, says Cranford. "The legal, political, administrative, and financial obstacles are enormous. It may be 20 years before system ethics committees make a difference."

Perhaps as they evolve, the various system-based ethics committees will develop a foundation of consensus, much as hospital ethics committees have done, despite the hospitals' diverse religious and corporate affiliations. There's surprisingly little difference in consultation outcomes among hospital ethics committees, says the Duluth Clinic's Camenga. "Decisions are based upon fact and the principles of kindness, fairness, and respect." MM

Howard Bell is a free-lance writer living in Onalaska, Wisconsin.

Minnesota Medicine is the official journal of the Minnesota Medical Association, and its purpose is to provide Minnesota physicians with timely information regarding all aspects of medicine so they can more capably serve their patients and more readily achieve their professional goals. Therefore, the editors are pleased to consider for publication clinical and health papers (clinical studies, reviews, case reports) and essays, letters, and opinion pieces related to medical practice in Minnesota.

Manuscripts

Submit clinical articles, essays, letters, book reviews, and other manuscripts at any time to: Meredith McNab, Managing Editor, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. Manuscripts are reviewed by the editors and peer reviewed by the Advisory Committee, the Review Board, and other experts in particular specialties.

Please submit two copies and keep one for your files. You may submit a Macintosh or IBM-compatible ASCII (text) floppy disk with your manuscript. Disks and copies of unpublished manuscripts will be returned to the authors. Only submit unpublished articles that have not been submitted elsewhere.

A cover letter should identify the author with whom we correspond (include address and phone number). Double-space all text on one side of paper only, including references, legends, etc., and number pages consecutively.

Receipt of manuscripts is acknowledged within 10 days, and authors are usually notified whether their manuscript is accepted within one to three months, but longer delays are sometimes unavoidable.

Title and Authors' Names

The first page of the manuscript should include: 1) a title—make it short, specific, and direct, 2) the full names of all authors, with their academic degrees, 3) authors' positions in hospitals or other institutions—include current position and the position held when the work reported in your manuscript was done, as well as academic appointments and other information pertinent to the paper's topic.

Abstract

The second page of the manuscript should include an abstract no longer than 150 words that highlights for the reader the essence of the authors' work. It should focus on facts rather than descriptions and should emphasize the importance and uniqueness of the findings and briefly list the approach used for gathering data and the conclusions drawn.

Author Responsibility

All authors should be involved in the drafting, revision, and intellectual content of the manuscript and be sufficiently familiar with the paper to defend its findings. Authors are responsible for all statements made in their work, *including changes made by copy editors*. Manuscripts are edited for clarity and grammar and to conform to *Minnesota Medicine* style, and authors receive an edited, word-processed copy of their paper for their review before it is sent to the printer. Once it is set in galleys, only *minor* changes can be made.

All authors sign a copyright form that conveys all copyright ownership to the Minnesota Medical Association. This form is mailed to the authors after a manuscript is submitted to *Minnesota Medicine*, and must be completed and returned before the article is published. If the manuscript is not accepted for publication, the form is returned to the authors.

Style

Use *JAMA* style or consult the AMA's *Manual for Authors & Editors*. Use generic drug names, unless citing a brand name relevant to your findings; brand names in parentheses may follow generic names if desired. Do not use abbreviations in the title, and limit their use in the text. Avoid medical jargon.

Tables

Tables must have a title and be on separate pages. If they occupy more than one page, type "*title* (cont.)." If the data in the tables have been previously published, appropriate reference should be given in the text, and permission should be obtained from the original publisher before submission to *Minnesota Medicine*.

Illustrations

Submit two copies of illustrations, keeping one for your files. Figures should be professionally drawn or photographed, if possible. We prefer glossy, clear black-and-white photographs, but color is acceptable if the contrast is good. Do not send original artwork.

Each figure should have a label pasted on the back indicating the figure number, author names, and the top of the figure. Legends should be included in the text of the manuscript with numbers corresponding to the figures. Do not mount figures on cardboard, write on the back of the figures, or attach paper clips to them. If a patient in a photo is identifiable, a written release form from the subject must accompany the photo.

References

All references must be cited in the text and should be arranged in the order in which they are cited in the text—*not* alphabetically. Journals should be abbreviated as in *Index Medicus*.

Examples:

1. Benson RC Jr. Laser photodynamic therapy for bladder cancer. Mayo Clinic Proc 1986;61:859-64.

2. Guttormson NL, Bubrick MP. Mortality from ischemic colitis. Dis Colon & Rectum, to be published.

3. Chaterjee SN. Use of GOR-TEX grafts as vascular access procedure for chronic hemodialysis. Abstract of a paper submitted to the European Society for Artificial Organs Eighth Annual Meeting, Copenhagen, August, 1981.

4. Thompson NW. Thyroid and parathyroid. In: Welch KJ, Randolph JG, Ravitch MM, et al., eds. Pediatric Surgery, 4th ed. Chicago: Year Book Medical, 1986: 522-33.

Financial Interest

List all affiliations with or financial interest in organizations that may have a direct interest in the subject matter of your manuscript. This information will be held in strict confidence until publication, and then will be printed with the article as is deemed appropriate in judging the validity of the article.

Reprints

Authors may order article reprints for a fee. Reprint request forms are sent to authors at the time of publication.

Pain Control at the End of Life

Thomas E. Elliott, M.D., F.A.C.P.

ABSTRACT

Pain control at the end of life is almost always achievable regardless of the cause. Most of the principles for managing pain at the end of life are derived from cancer practice. However, this knowledge can be extended to patients with pain from other illnesses at the end of life. Pain assessment is the most impartant step toward achieving optimal analgesia. It determines the appropriate analgesic therapy; drug dose and route of administration; drug dosing intervals; titration of drug doses; control and prevention of analgesic side effects; and application of adjuvant, loco-regional (nonsystemic), and invasive treatments. A comprehensive approach that integrates patient preferences and management of psychosocial and spiritual/existential companents of the patient's pain and suffering with physical companents will improve analgesia, reduce the burden of the illness and its treatment, and improve the patient's quality of life.

Pain at the end of life is common, occurring in up to 90% of cancer patients,[1] 80% of AIDS patients in the terminal phase,[2] and 60% of patients dying of end-stage organ failure.[3] Pain is usually the most prominent symptom affecting patients' quality of life. It is confounded by a high prevalence of other symptoms, such as dyspnea, nausea, fatigue, weakness, insomnia, confusion, depression, constipation, and anorexia. Dying patients experience an average of 11 symptoms besides pain. Cancer pain can be effectively treated with a comprehensive approach in up to 90% of patients. Although few studies have been published on pain management outcomes in patients dying of AIDS and end-stage organ failure, similar results can likely be achieved. No patient at the end of life needs to live or die with unrelieved pain.

Minnesota statute[4] and U.S. Supreme Court opinions[5] have supported the principle of double effect, which protects physicians from legal liability when they prescribe analgesics for pain relief. In pain management, the opioid dose required may sometimes cause obtundation and respiratory depression and even death, directly or indirectly. The principle of double effect justifies this action when the intention is to relieve pain and suffering, but this effect can be achieved only at the risk of producing a harmful effect. The principle was formulated by Roman Catholic moral theologians in the 17th century and has been confirmed by bioethicists in this century. Another issue that remains a barrier to pain control is concern about addiction. Addiction is rare when opioids are used for pain management; it is irrelevant in patients with pain at the end of life.

This article reviews the pharmacologic treatment and other medical interventions of pain management at the end of life for application in clinical practice. Although most of our knowledge about acute and chronic pain management is derived from cancer pain, the same principles, assessments, drugs, and other treatments apply to pain related to other diseases at the end of life. Readers are referred to more extensive review articles,[6-8] guidelines,[1,9] and textbooks[10-12] for more detailed information.

Pain Assessment

Initial and continuous pain assessment is critical to achieving optimal analgesic results. The sine qua non of pain assessment is the patient's self-report. Simple pain rating scales should be used. The most popular and well-validated pain-intensity rating scale is the numerical zero to 10 scale, where zero means no pain and 10 means the worst pain imaginable. Alternative assessment tools are available for patients of different ages or developmental abilities and for patients who prefer a different rating scale. Other components of pain assessment include location, radiation, what the pain feels like, exacerbating and relieving factors, past and current treatment effectiveness, patient concerns and compliance, and pain's effects on function, mood, and sleep. Pain assessment includes a careful focused physical examination and diagnostic tests that will aid in treatment decisions.

Pain should be assessed at regular intervals, at each new report of pain, and at a suitable interval after each intervention. Pain assessment determines all analgesic decisions, such as drug selection, dose, dose interval, titration, and route. Furthermore, pain assessment helps prevent and

Table 1

Key elements of pain assessment

I. Pain intensity and character
- 1. Onset and temporal pattern
- 2. Location(s)
- 3. Description
- 4. Intensity score; e.g., 0-10 scale where 0=no pain; 10=worst pain imaginable
  - Patient rates:
  - a. pain now
  - b. worst pain last 24 hours
  - c. least pain last 24 hours
- 5. Aggravating and relieving factors
- 6. Previous treatment
- 7. Effects on physical and social function

II. Psychosocial assessment
- 1. Mood
- 2. Concerns
- 3. Coping
- 4. Treatment preferences
- 5. Patient's goals
- 6. Information needs

III. Physical and focused neurologic examination

manage analgesic drug side effects, including overdose. Assessment includes evaluating the psychosocial, financial, and spiritual components of pain and suffering. Finally, assessment should determine what pain level is acceptable to the patient and make it the common goal. Table 1 displays the key elements of pain assessment.

Pharmacologic Principles

Drug selection

Analgesic drug selection is based on the pain intensity score and other patient variables. Pain ratings of 1 to 4 correspond to mild pain; 5 to 6, moderate pain; and 7 to 10, severe pain. The World Health Organization uses the following three categories of pain to guide analgesic drug selection: for mild pain select a nonopioid (step 1 drug), such as acetaminophen, aspirin, or other NSAIDs; for moderate pain select an opioid in addition to the nonopioid (step 2 drug); and for severe pain select a strong opioid (step 3 drug). Patients who do not achieve an optimal analgesic result should have their current analgesics titrated to a maximal ceiling dose in the case of nonopioids, and to optimal analgesia with acceptable side effects in the case of opioids. For the preferred opioids, such as morphine, hydromorphone, fentanyl, and oxycodone, there is no ceiling dose for most patients.

The step 2 opioids include codeine, dihydrocodeine, hydrocodone, and oxycodone in combination with either aspirin or acetaminophen. Step 2 opioids are used only for moderate pain because of dose-limiting side effects or because they are combined with nonopioid analgesics. Step 3 opioids include morphine, hydromorphone, fentanyl, and oxycodone. Morphine is the analgesic of choice for most patients. Methadone and levorphanol may also be considered but are not recommended for initial therapy because of their long half-lives and the risk of drug accumulation.

Opioids not recommended for treating pain at the end of life include meperidine, buprenorphine, pentazocine, butorphanol, dezocine, and nalbuphine. Meperidine has a short duration of analgesic effect and a toxic metabolite. The other analgesics are mixed opioid agonists-antagonists and have low efficacy, high risk of adverse effects, and cause physical withdrawal syndrome when taken with full agonists. Propoxyphene is not recommended for routine use because of its long half-life, risk of accumulation of a toxic metabolite, and low efficacy.

Adjuvant drugs may be used at any step to 1) enhance analgesia, 2) treat concurrent symptoms that exacerbate pain, and 3) provide independent analgesia for specific types of pain. More detailed discussion of adjuvant drugs is presented later.

Analgesic dose

The appropriate dose of a step 3 opioid optimally relieves pain without causing intolerable side effects. The starting dose of morphine or other step 3 opioids depends on pain intensity, dose of previous analgesics, and patient's age and weight. Suggested starting doses are shown in Table 2. Doses required to control pain after careful titration may range from 30 mg of oral morphine or its equivalent per day to many thousands of milligrams of parenteral morphine per hour.

Switching from one opioid analgesic drug to another, changing route of administration, and moving up the analgesic steps requires knowledge of the dose equivalents among drugs and routes. Table 2 shows suggested dose and route equivalents in chronic cancer pain patients. Because there is not complete cross-tolerance among these drugs, it is usually necessary to use a lower than equianalgesic dose (25% to 50% reduction) when changing drugs and to rapidly retitrate to response. When changing route, but not opioid drug, this suggested reduction is not necessary.

Route of analgesic drugs

The oral route is preferred for most patients because it is simpler, easier to use, and less expensive than other routes. If a patient cannot swallow, other routes to consider include sublingual, buccal, rectal, transdermal, subcutaneous, or intravenous. Intramuscular route is not recommended because it is painful, more difficult for family caregivers to administer, and has poorer bioavailability com-

pared with subcutaneous or intravenous routes. The dose and schedule for sublingual, buccal, and rectal routes are generally the same as those for the oral route. Subcutaneous and intravenous routes have the same dose and schedule. Various opioid formulations specific to these routes are commercially available.

Analgesic dose schedule

Analgesic drugs should be ordered at intervals that prevent the recurrence of pain and minimize the number of daily doses. The appropriate dosing interval is determined by the opioid used and its route of administration. If pain recurs sooner than the expected duration, the dose should be increased until the pain is controlled without toxicity during the expected dosing interval. Since most patients with end-of-life illness have continuous or near continuous pain, continuous, around-the-clock (not prn) dose schedules will be necessary.

Pain prevention

Prevention of pain and relief of breakthrough pain will require supplemental, rescue doses of analgesic drugs in addition to the regularly scheduled dose. An appropriate breakthrough dose would be 50% to 100% of the regular dose given for that interval. For example, a patient on 20 mg of morphine (immediate release) every 4 hours should be provided 10 mg to 20 mg of morphine every 4 hours as needed (prn). If more than three to four breakthrough doses per day are used, then an increase in the baseline dose is needed.

Titration of opioid analgesics

Achieving optimal analgesia with acceptable side effects requires constant opioid dose titration based on pain assessments. For patients with severe, unrelieved chronic pain (pain intensity scores of 7 to 10), the total daily dose of morphine should be increased by 50% to 100% every 24 hours. Moderate unrelieved pain should be treated with daily increases of 25% to 50%. The end point of titration is optimal analgesia defined by the patient's goals, e.g., pain scores of 0 to 3 with acceptable side effects.

Patients whose pain is eliminated by neurolysis, neurosurgery, or other pain-relieving procedures may need rapid downward titration of the opioid. When pain is absent or minimal, or opioid side effects are present, the opioid dose should be decreased by 25% to 50% each day until the side effects become tolerable or pain just reemerges. Patients with substantial side effects may need to have one or two doses withheld and subsequent doses reduced by 50% to 75%. To avoid a physical withdrawal syndrome, at least 25% of the previous day's dose should be continued.

Table 2

Step 3 opioid analgesic drugs; oral and parenteral dose equivalents

Generic name (proprietary name)	Route	Dose equivalent (mg)	Usual starting doses (mg)*
Morphine† (various)	oral parenteral	30 10	15-30 5-10
Hydromorphone (Dilaudid)	oral parenteral	6 1.5	4-6 1-1.5
Oxycodone (various)	oral	20-30	15-30
Fentanyl‡ (Duragesic)	transdermal	100 mcg/hr every 72 hrs.	50-100 mcg/hr every 72 hrs.

*For moderate to severe chronic pain. Doses are milligrams every 4 hours, except for transdermal fentanyl.

†Morphine is available in tablets and liquids taken every 4 hours as "immediate release" preparations and in controlled-release tablets and capsules taken every 8, 12, or 24 hours. The 8-hour, 12-hour, and 24-hour doses are 2, 3, and 6 times the 4-hour dose, respectively.

‡The microgram-per-hour dose of transdermal fentanyl is equal to one-half of the milligram-per-day dose of oral morphine.

Managing side effects of opioid analgesics

Optimal analgesia requires prevention of side effects. The most common side effect is constipation. Nearly all patients on opioids need regular laxative therapy. Little to no tolerance develops to opioid-related constipation. Opioid-related nausea may require an antiemetic drug such as prochlorperazine, haloperidol, or metoclopramide. For most patients, nausea resolves spontaneously over a few days following initiation or upward titration of an opioid.

Sedation, confusion, and delirium usually improve as tolerance develops over several days. Avoiding other sedative drugs is recommended. Persistent sedation caused by opioid analgesia can be improved with caffeine or methylphenidate. Confusion and delirium can be reduced with haloperidol. Respiratory effects are rare and avoidable. Patients on chronic opioid analgesia who have pain and are awake or sedated but arousable cannot have opioid-induced respiratory depression. Opioids cannot cause respiratory depression even in obtunded, pain-free patients if the dose has not been changed in the previous 48 hours. When respiratory failure occurs in these patients, it is due to other processes, such as pulmonary embolism, pneumonia, other drugs, or the dying process itself. Naloxone is rarely necessary or appropriate at the end of life.

continued

Table 3

*Adjuvant analgesic drugs**

Drug class/common drugs	Usual dose ranges
NSAIDs	
aspirin	650 mg q. 4 hr
ibuprofen	400-600 mg q. 6 hr
trisalicylate†	1.0-1.5 g q. 8 hr
Corticosteroids	
prednisone	20-40 mg bid-tid 40-80 mg q. 6hr‡
dexamethasone	4-8 mg bid-tid 10-20 mg q. 6 hr‡
Antidepressants	
amitriptyline§	25-150 mg q. hs
trazodone§	75-225 mg q. hs
Anticonvulsants	
carbamazepine§	200 mg bid-qid
clonazepam	0.5-1.0 mg tid
Psychostimulants	
Methylphenidate	5-20 mg q. AM, 5-10 mg q. noon

*These drugs are commonly used in combination with other analgesic drugs for cancer pain.

†Trisalicylate=choline magnesium trisalicylate.

‡These higher doses are indicated in acute spinal cord compression and severe increased intracranial pressure.

§Monitor serum drug levels to achieve therapeutic levels and avoid toxicity.

Strategies for complicated pain management

A fraction of dying patients treated with these simple approaches will have inadequate analgesia or unacceptable side effects. The most important strategy for these complicated pain problems is reassessment of the pain and its components. A new pain etiology may be present, such as a pathologic fracture, neurocompressive syndrome, or constipation. A revised pain management approach will be necessary. Patient compliance should be explored. Commonly held misconceptions concerning addiction, loss of control, and dyscognition may cause patients not to take opioids as prescribed. Addressing nonphysical components of pain and suffering is also necessary. Opioids will not improve pain related to family dysfunction, existential distress, social isolation, or depression.

Nearly all physical pain responds to opioids to some extent. Continued titration trials of an opioid is appropriate until incremental analgesia is not obtained or unacceptable side effects cannot be managed. Rotating from one opioid to another may be an appropriate strategy, such as switching from morphine to hydromorphone. Because of an idiosyncratic response to a particular opioid or unique metabolites associated with an opioid, rotating to an alternative opioid may result in improved analgesia with acceptable side effects. As stated earlier, the initial dose of the new opioid should be 25% to 50% less than the estimated equivalent dose because of incomplete cross-tolerance.

The use of adjuvant drugs may also help. These drugs enhance the analgesic effects of opioids, treat concurrent symptoms that exacerbate pain, or produce independent analgesia for specific types of pain. Adjuvant analgesic drugs include NSAIDs, corticosteroids, tricyclic antidepressants, anticonvulsants, and psychostimulants. NSAIDs are effective in managing inflammation-based pain and are step 1 nonopioid analgesics. Corticosteroids are useful in pain caused by nerve compression, visceral distention, increased intracranial pressure, and inflammation-based pain. Tricyclic antidepressants are efficacious in treating chronic neuropathic pain and in improving depression and insomnia. Anticonvulsants can help control intermittent neuropathic pain, either alone or in combination with tricyclic antidepressants. Psychostimulants may improve opioid-related sedation and relieve pain and depression. Table 3 shows adjuvant analgesic drugs commonly used in combination with analgesic drugs for cancer pain.

Pain not well controlled by systemic opioids and other strategies described above will require a loco-regional analgesic approach. These approaches include using radiotherapy and radiopharmaceuticals (e.g., strontium-89) for malignant disease, stabilizing or fixing fractures, draining abscesses, applying spinal analgesia, and using neurolytic and neurosurgical procedures. Decision-making for loco-regional interventions must include the patient's preferences and the prognosis, careful consideration of burdens and benefits, and the technical capability of the health care delivery system. Patients with complicated pain should be referred to pain specialists for consultation and application of appropriate treatments.

Treating Nonphysical Causes of Pain

Psychosocial and spiritual pain may be evident in patients experiencing anxiety, depression, isolation, fear, financial concerns, loss of role, altered body image, and loss of faith and meaning. Supportive counseling,

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142

E-Mail: stephanie.l.jussila@qm.healthpartners.com



Central Minnesota Group Health Plan

HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220

Credentialing "What If's"

A Powerful New Tool for Credentialing

- Provides a unique, hands on guide to the skills needed for credentialing
- Shows you how to decrease risk and assure the quality of potential providers
- Includes a step-by-step guide to credentialing processes and procedures

Please call (612)992-3095 for more information

"...what Allina did for our careers was great; what they did for our families was amazing."

Allina knows what's important to our physicians. That's why we've created a progressive, not for profit health organization that values your time and talent. We offer desirable call schedules and excellent physician support, allowing you to do the work you love, without abandoning your loved ones. Allina is currently seeking physicians in the following categories: Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, Locum Tenens, and Dermatology.

Our Minnesota/Wisconsin locations have numerous metro and rural opportunities —along with our rewarding career structure, excellent compensation package, and family relocation assistance.

If you love your work, you'll love Allina.

Call our Physicians Services Group

612-992-3093 or 1-800-248-4921

Fax 1-612-992-3669

Allina Health System . Route 80775

5601 Smetana Drive . Minnetonka, MN 55343

ALLINA
HEALTH SYSTEM

CONTINUING MEDICAL EDUCATION

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

NOVEMBER, 1997

14 FRONT LINE NEUROLOGY
Presented by: Minneapolis Neuroscience Institute
Location: Minneapolis Radisson, Minneapolis

14-15 EVIDENCE BASED PERINATAL CARE A LEARNING/WORKING CONFERENCE
Presented by: Allina Health System - Pregnancy Care Clinical Action Group
Location: Grand Hotel, Bloomington

15 FIFTH ANNUAL ORTHOPEDIC SYMPOSIUM
Presented by: Unity/Mercy Hospitals
Location: Earle Brown Center, Brooklyn Center

21 - 22 NEW ULM FALL SEMINAR
Presented by: New Ulm Medical Center
Location: New Ulm Medical Center, New Ulm

For more information, contact Allina Clinical Education and Research - (612) 992-2424

™ A Trademark of Allina Health System

Visit the Allina CME calendar at http://www.allina.com

nonjudgmental listening, and information can often relieve mild nonphysical pain. Complicated and moderate to severe nonphysical pain may require pharmacological treatment, especially for depression and/or anxiety, and referrals to religious or spiritual advisers and a psychotherapist or social worker. Physicians need to provide wanted information to the patient and family, help redefine hope, and assist with the search for meaning and growth in the last phase of life. For the team of other health care providers caring for the patient and family, the physician should provide leadership in assessing and treating pain, establishing the goals of care, making decisions with the patient and family, and deriving prognosis.

Pain Management During Active Dying

Pain is experienced during active dying despite obtundation. Opioids should not be reduced or stopped in most patients. Discontinuing opioids will cause physical withdrawal syndrome, which is painful. Most patients will need the same dose or a higher dose until death. In one series, opioid doses given to patients in the last 48 hours of life were reduced in 13%, increased in 44%, and unchanged in 43%. When respiratory depression and arrest occurs, it is due to the dying process, not the use of opioids. Pain assessment may be difficult during the dying process. Some nonverbal signs of pain are grimacing, moaning, increasing irritability, restlessness and interrupted sleep, and changes in breathing. Routes of opioid administration often must be changed because patients become unable to swallow. Alternative routes are rectal, transbuccal, transdermal, subcutaneous, and intravenous. Opioids can be very helpful for controlling other symptoms during dying, such as dyspnea, tachypnea, anxiety, insomnia, and restlessness.

Conclusion

If pain assessment is done well, pain can be controlled at the end of life, as it is in cancer patients with acute and chronic pain throughout their illness. Comprehensive pain assessment improves analgesia, reduces adverse effects of analgesia, and improves patients' quality of life. Analgesic drugs are the cornerstone of pain management. Often drugs from several pharmacologic classes are required. Occasionally, invasive drug delivery systems or other loco-regional techniques are indicated. Most analgesic drug side effects can be prevented or easily controlled. Many symptoms occurring at the end of life are not due to opioid analgesics, but to the dying process itself. Regardless of the cause, these symptoms should be assessed and treated. Complicated pain problems or unacceptable analgesic outcomes as defined by the patient should be managed in collaboration with pain experts. Improving pain control at the end of life will benefit hundreds of thousands of patients and families. MM

Thomas Elliott is medical director of St. Mary's Hospice in Duluth, medical director of the Pain Management Program at St. Mary's Medical Center in Duluth, a medical oncologist with Saint Mary's/Duluth Clinic Health System (SMDC), director of the SMDC Division of Education and Research, and a clinical professor at the University of Minnesota–Duluth School of Medicine. He was medical director of St. Luke's Hospital's Hospice Duluth from 1978 to 1990 and president and chair of the Minnesota Cancer Pain Initiative from 1989 to 1996.

REFERENCES

1. Jacox A, Carr DB, Payne R, et al. Management of cancer pain: clinical practice guideline. No. 9. Rockville, Maryland: Agency for Health Care Policy and Research, 1994 (AHCPR publication no. 94-0592).
2. Britton CB, Miller JR. Neurologic complications in acquired immunodeficiency syndrome (AIDS). Neurology Clinics 1984;2:315.
3. Seale C, Cartwright A. The year before death. Brookfield, Vermont: Ashgate Publishing Company, 1994.
4. Minn. Stat. Ann. § 609.215 Subd. 3.
5. Washington v. Glucksberg, __US__117 S.Ct. 2258, 138 L.Ed. 2d 772 (June 26, 1997).
6. Foley KM. The treatment of cancer pain. N Engl J Med 1985;313:84-95.
7. Cherny NI, Portenoy RK. The management of cancer pain. CA Cancer J Clin 1994;44:263-303.
8. Levy MH. Pharmacologic management of cancer pain. Semin Oncol 1994;21: 718-39.
9. American Society of Anesthesiologists Task Force on Pain Management. Practice guidelines for cancer pain management. Anesthesiology 1996;84:1243-57.
10. Patt RB, ed. Cancer pain. Philadelphia: J.B. Lippincott, 1993.
11. Doyle D, Hanks GWC, MacDonald N, eds. Oxford textbook of palliative medicine. Oxford, England: Oxford University Press, 1993.
12. Twycross R. Pain relief in advanced cancer. London: Churchill Livingstone, 1994.

ASPEN Medical Group

Full Time Urgent Care Internal Medicine

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 10 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

The Monitor

NEWS FOR MINNESOTA PHYSICIANS

Announcements

MMA Joins Hepatitis C Coalition

The MMA has joined the Minnesota Hepatitis C Coalition to increase general awareness of Hepatitis C, to alert people about the risk factors associated with the virus, and to disseminate information about what treatment options exist. One goal of the coalition is to develop educational materials for physicians. Approximately 2 percent of the U.S. population is estimated to be infected with the disease. November has been declared Hepatitis C Awareness Month in Minnesota.

• • •

MMBR Introduces Medical Practice Resources

Minnesota Medical Business Resources (MMBR) introduces Medical Practice Resources, a new medical placement service that provides national recruitment or placement opportunities through a toll-free call or on the Internet web site. This cutting-edge use of the Internet allows physicians to quickly search through postings by specialty or location and to respond confidentially by dictating a mini-CV via voice mail or by completing an application form online. Candidate responses are faxed the next business day. Special rates are available for placement in both Medical Practice Resources and/or *Minnesota Medicine*, the monthly journal of the MMA. To learn more about this service or to place a position, call David Franz at 888/884-8241. Medical Practice Resources is a joint venture of MMBR and Applied Recruitment Technologies.

MMA Works with Congress on Kyl/Archer Legislation

The Minnesota Medical Association is asking Minnesota's congressional delegation to support federal legislation that would loosen restrictions on private contracting between physicians and Medicare beneficiaries.

Although the Balanced Budget Act of 1997 opened the door to allow private contracts between doctors and Medicare patients—free from Medicare balance billing and claims filing requirements—physicians entering into such contracts must pledge not to receive any Medicare payment for two years. Legislation initiated by Sen. Jon Kyl, R-Arizona, and Rep. Bill Archer, R-Texas, would change that, repealing the two-year ban provision.

The bills, S. 1194/H.R. 2497, would allow Medicare patients to pursue contracts with doctors more freely—without isolating physicians from the Medicare program for simply having Medicare patients who prefer, for whatever reason, to privately finance their own health care. The legislation would ensure important beneficiary protections by including reasonable requirements relating to a description of the scope of services to be rendered and other applicable terms of contract.

Critics of the bill charge that it could exacerbate Medicare fraud and abuse. Many state medical societies and associations have urged lawmakers to support the legislation, maintaining that it would give seniors more treatment choices while lessening financial pressures on Medicare. Rep. Jim Ramstad and Sen. Rod Grams have signed on as co-sponsors. • • • • •

Congress Urged to Hold Out for Effective Tobacco Settlement

After Gov. Arne Carlson sent Commissioner of Health Anne Barry and Commissioner of Commerce Dave Gruenes to Washington, D.C., to testify in favor of an immediate tobacco settlement, the MMA wrote to Minnesota's congressional delegates, urging them to continue to hold out for an effective solution to the problem of tobacco addiction—no matter what form that solution may take.

Whether the solution is in the form of a global settlement, legislation, or through the process of continued litigation is not as important as the content and effect of the solution. Public health concerns must be paramount.

The MMA also reiterated its support for seven key provisions that should be included in the solution, including giving full authority to the Food and Drug Administration to regulate tobacco products. A major weakness in the June proposal to settle state lawsuits and class actions against tobacco companies was the proposed change in the FDA's authority to regulate nicotine. • • • • •



Viewpoint

Paul C. Matson, M.D., Chair
MMA Board of Trustees

MMA Addresses Physician Relationships

As I begin my term as chair of the board of trustees, I want to congratulate my predecessor Timothy Crimmins, M.D., on his outstanding leadership during the past three years. We can look back with pride to recent accomplishments such as our Stop the Violence and anti-tobacco campaigns and our legislative victories including repeal of the $400 surcharge and reduction of the provider tax.

I appreciate the confidence expressed in me in the election process and look forward to the challenges ahead for the organization and for Minnesota physicians.

During the 1997 MMA Annual Meeting, our House of Delegates set an agenda for the coming year that expresses our collective will. This association does not exist apart from physicians, but embodies our philosophy and voices our opinions on a broad variety of issues. Many of the 1997 resolutions reflect concern about the important relationships of physicians with their community, their patients, and their profession.

Physician Relationships with the Community: Public Health

Several resolutions address public health issues such as tobacco addiction. The House of Delegates commended Attorney General Hubert H. Humphrey III for pursuing the Minnesota suit against tobacco companies. When Gov. Arne Carlson sent the commissioners of health and commerce to Washington, D.C., to urge Congress to immediately settle the state lawsuits against the tobacco industry, the MMA asked our Minnesota delegation to only support a solution that incorporates the seven key provisions considered essential according to MMA policy. One of the most important provisions would ensure that the Food and Drug Administration would continue to have full authority to regulate tobacco products.

The MMA will continue to educate the public about the dangers of second-hand smoke. University of Minnesota Cancer Center researchers recently found evidence of a tobacco-specific carcinogen in the lungs of nonsmokers exposed to cigarette smoke. Soon after this study was published, the House of Delegates directed the MMA to encourage all parents to declare their homes smoke-free zones.

As an association, we reaffirmed our policy not to invest in tobacco company stocks or to accept financial or other contributions from tobacco companies.

Physician Relationships with Patients: Professionalism

Many of the resolutions adopted by the House of Delegates reflect growing concern about our ability to preserve the essential physician/patient relationship and maintain professionalism in an increasingly competitive marketplace. The MMA has supported legislation that bans gag clauses, allowing physicians to discuss all treatment options with their patients; bans exclusive contracts and the denial of coverage for essential services; as well as other measures to preserve patient access to medical care.

The MMA continues to meet with health plan representatives, legislators, and others to discuss quality care, cost containment, and product pricing. We urge health care systems to avoid pricing their products in order to gain market share to such an extent that they are later forced to reduce services, cut benefits, or limit access to care for their enrollees.

Physicians are not alone in their concern about achieving an appropriate balance between cost and quality. In a recent Gallup survey of HMO and PPO senior executives, 34 percent reported that controlling costs while delivering quality care was the most important challenge they faced. The MMA will continue its dialogue with health care systems and will provide leadership on this important issue.

Relationships with Other Physicians: The MMA

The MMA represents physicians practicing in diverse clinical and economic settings who are at various points in their careers. The membership encompasses practices that are large and small, rural and urban, with male and female physicians of all races and creeds. Currently, the MMA is going through a process of critical self-analysis to determine how best to serve you in this period of changing health care delivery. The MMA Strategic Planning Committee has completed a comprehensive survey of member and non-member physicians and is evaluating how the MMA can be as efficient, effective, and inclusive as possible.

With your help, we will succeed.

Community Service Awards Presented at MMA Annual Meeting



Wayne D. Liebhard, M.D., a family physician at the Prior Lake Clinic, accepts a 1997 Physician Award for Community Service from past president Michael Murray, M.D., during the MMA Annual Meeting in Brainerd.

The MMA has presented its 1997 Physician Awards for Community Service. The recipients are Robert O. Fisch, M.D., of Minneapolis; Wayne D. Liebhard, M.D., of Prior Lake; and Timothy J. Rumsey, M.D., of St. Paul. The Community Service Awards honor physicians who have performed outstanding service to their communities in addition to their practice of medicine. The awards were presented September 15 at the MMA Awards Lunch at Madden's Resort in Brainerd as part of the MMA's 144th Annual Meeting.

Robert O. Fisch, M.D., a pediatrician at the University of Minnesota Hospital and Clinic, is a scientist, teacher, artist, and humanitarian. Fisch initiated Project Read, a popular program in which volunteers in clinic waiting rooms read to young children using books Fisch has convinced publishers to donate. For 40 years, he has served as an educator of medical students and pediatricians, teaching not just the science of medicine, but also the art of health care. He has conducted landmark research in the field of phenylketonuria (PKU), a chronic disease that, when identified in early childhood, can be arrested and reversed with appropriate diet and treatment. Finally, Fisch—who came to the United States from Hungary as a Holocaust survivor—has enriched his community, and the world, through his work as an artist. His experiences in the Treblinka concentration camp, where many of his family members were murdered, led him to create a series of paintings that have been exhibited across the U.S. and in Europe. His redemptive vision has inspired everyone, young and old, with whom he has come in contact.

Wayne D. Liebhard, M.D., a family practitioner, is a staff physician at the Prior Lake Clinic, serves as home health medical director at Belle Plaine Lutheran Home, and works as an emergency physician at Fairview Ridges Hospital House. Since 1987 he has taught at the University of Minnesota, first as a clinical instructor and now as an assistant professor. Liebhard has been an aggressive advocate for students and alumni at the university; he made the unusual commitment of returning to serve a second term as Medical Alumni Society president. His involvement in service organizations, youth clubs and athletics, his church, and the arts make Liebhard a fine example of a "community physician."

Timothy J. Rumsey, M.D., a family practitioner, is a staff physician at United Family Practice in St. Paul. Rumsey has long demonstrated care for and a commitment to poor and homeless people in his community. He has worked with the Health Care for the Homeless Project in Ramsey County since 1982. Rumsey is a physician for a weekly walk-in clinic at the Dorothy Day Center. He also coordinates the Homeless Pharmacy project with the help of volunteer pharmacists and pharmaceutical representatives. The homeless pharmacy has reduced monthly bills from as high as $1,250 per month to as low as $80 per month. And Rumsey is a prolific and respected writer, penning works ranging from a critically acclaimed novel to health columns in newspapers and magazines. • • • • •

Health Care Consumer Advisory Board Working on Reports

• • • • • The Health Care Consumer Advisory Board has met and is planning to issue reports on utilization review and on an appeals process with health plans. The board will be taking testimony November 10 on both of those issues; for more information, contact Janet Silversmith at the MMA at 612/378-1875 or 800/342-5662. The MMA will continue to monitor the progress of the board; watch future issues of *The Monitor* for more information.

Media, Minority Service, and Sova Awards Presented in Brainerd

The MMA presented its Awards for Excellence in Medical Journalism at the Annual Meeting in Brainerd on September 15. The media awards are given to reporters who have contributed to a better understanding of medicine and health in Minnesota. Entries are judged by a panel that includes physicians who verify the medical accuracy of each entry. The articles are judged on five criteria: accuracy, significance, quality, public interest, and impact.

The 1997 MMA Media Award winners in the category of Health Promotion and Disease Prevention are:

• *The Duluth News-Tribune*, Kendra Rosencrans, health choices reporter, for "Ounce of Skepticism Helps, Too," an article exploring the responsibilities of journalists who report medical news and offering ways readers can make sense of the daily flow of health news dominating print and broadcast media. The award also honored Rosencrans for another package called "Final Lessons," a series about a college professor dying, with dignity and grace, of colon cancer and the hospice program that helped ease his passage. Photographer Dave Ballard received an award for his collaboration with Rosencrans on "Final Lessons."

• KTCA-TV's "Newsnight Minnesota," Carolyn Will, writer/producer/reporter, for "Red Lake Diabetes," a report examining high rates of diabetes among Red Lake tribal members and profiling the physician and nurse at Indian Health Services who have dedicated themselves to helping tackle the problem.

In the category of Violence as a Health Issue, the 1997 winner is:

• *The Pine River Journal*, Kirsti Marohn, editor/reporter, for "Cass Steps Up Fight Against Domestic Abuse," an article about domestic abuse in Cass County, the programs available for victims, and the need for more support services.

In addition to the media awards, the MMA gave its Physician Communicator Award to Ronald D. Franks, M.D., former dean of the University of Minnesota-Duluth School of Medicine. The judges said Franks demonstrated "exemplary skills in communicating with the public" in championing the needs of rural Minnesota health care providers and patients. He helped spearhead development of the Minnesota Rural Health School; under his leadership, the University of Minnesota–Duluth School of Medicine became nationally recognized for producing excellent rural physicians. Franks began working as dean of the medical school and vice president for health affairs at East Tennessee State University in September.

Minority Service Award Goes to the Late Dr. Ellis

The Minnesota Medical Association gave the 1997 Minority Service Award to the late Cassius Marcellus Clay Ellis III, M.D. The posthumous award was accepted by his wife, Phyllis H. Ellis, September 15 at the MMA Awards Lunch in Brainerd during the Annual Meeting.

Dr. Ellis, a general and vascular surgeon, served as a mentor to countless minority physicians, medical students, and residents in Minnesota and across the country. He was assistant dean for minority affairs at the University of Minnesota Medical School and was a clinical professor of surgery, training—and attracting—numerous medical students over the years.

Ellis also served as director of surgical education at North Memorial Medical Center in Robbinsdale and was a surgery consultant at St. Paul Ramsey Medical Center. He worked with the Pilot City Health Center and the Model Cities Health Center, and had leadership roles in many professional organizations, including the Hennepin County Medical Society, the Minnesota Board of Medical Examiners, the American Medical Association, the American College of Surgeons, and the International College of Surgeons.

He earned dozens of awards, both within and outside of the medical profession, including the Gender Equity Award from the American Medical Women's Association. His many civic endeavors included chairing the Penumbra Theatre Board, being an active member of Sigma Pi Phi Fraternity Omicron Blue, and working with the NAACP.

MMA Presents Sova Award to Tom Swain

The Minnesota Medical Association presented the James H. Sova Memorial Award to Tom Swain, former chair of the Minnesota Health Care Commission. The award was given September 15 at the MMA Annual Meeting in Brainerd.

The James H. Sova Memorial Award is presented to a person outside of the medical profession who has made a significant contribution to the advancement of medical sciences, medical education, medical care, or the socioeconomics of medical practice. The award was created in 1982 in memory of James Sova, the chief lobbyist for the MMA from 1968 until his death in 1981.

Swain dedicated a great deal of time and effort, both in his career positions and as a volunteer, to improving the health of Minnesotans. As chair of the Minnesota Health Care Commission, from its inception in 1992 through 1995, Swain worked diligently and thoughtfully to build consensus from many diverse points of view. The result was the MinnesotaCare program, cited nationally as an exemplary effort toward universal coverage. The commission also played an important public health role under Swain, advocating preventive medicine and healthier lifestyles. He also has served as director of the Courage Center and director of Select Care. • • • • •

Recent Studies Reaffirm Benefits of "Five-a-Day" Diet

If anyone had trouble swallowing the MMA's resolution a year ago supporting the "Five-a-Day" program, a recent report sponsored by the American Institute for Cancer Research and its affiliated World Cancer Research Fund offered fresh evidence to back up the recommendation.

The sweeping report on diet and cancer, issued in late September, concluded that up to 40 percent of all cancers could be avoided by changing lifestyles and eating habits. It stresses the importance of eating at least five servings daily of fruits and vegetables. The report also encourages Americans to eat less red meat, and more legumes and whole grains.

A clinical study of the effects of a diet rich in fruits and vegetables on blood pressure, detailed in an April article in the *New England Journal of Medicine*, supports Five a Day from another angle. The study, "Dietary Approaches to Stop Hypertension," showed that patients who consume plenty of fruits, vegetables, and low-fat dairy foods can substantially lower their blood pressure.

Hundreds of studies had already shown relationships between fruit and vegetable intake and cancers of the lung, colon, breast, cervix, esophagus, mouth, stomach, bladder, pancreas, and ovaries, said Donald D. Hensrud, M.D., a consultant in preventive medicine and nutrition at Mayo Clinic.

Hensrud, who pressed for passage of the Five-a-Day resolution, said he hopes to see nutritional recommendations turning more toward what people can and should eat more of—namely, fruits and veggies—instead of always focusing on what they shouldn't eat.

"The data are consistent and significant," he said. Switching to a more plant-based diet can help prevent a wide range of problems, including (in addition to cancer) stroke, heart disease, gall bladder disease, and diverticulosis.

"Here's something that *anybody* can do," Hensrud emphasized, and people who hear it from their physicians may be more apt to follow through.

Hensrud said physicians often hear patients say they're too busy to eat nutritious meals. But harried working people who've grown accustomed to falling back on prepackaged or "fast" foods needn't become gourmet cooks or spend lots of extra time grocery shopping to positively alter their diets: "Throw three pieces of fruit in a bag and bring it for lunch or a snack," he suggested. "Keep a fruit bowl around the house, in plain sight."

Good habits are often as easy to form as bad ones, Hensrud said. After a few weeks of snacking on oranges or bananas, many people find their cravings for greasy burgers and bags of potato chips become less and less frequent.

"Taste preferences change, once people try it and make it a part of their lives. It's just making the initial effort.

"It sounds just like your mother, but [more and more] there's real scientific evidence to back it up," Hensrud said. • • • • •

Study Examines Violence in TV Commercials

• • • • • While TV ratings systems may help parents shield their children from *programs* filled with violence and gore, violent *commercials* can appear anytime, even during "family" programming. That's the message in a report by Minnesota family physician Charles Anderson, M.D., which examines commercials aired during the 1996 Major League Baseball playoffs and World Series.

Anderson, whose report was published in *JAMA*, found violent content in 104 of the 1,528 commercials he taped—an average of 10 violent commercials per game during the World Series, six per game during the American League Championship Series, and three per game during the first-round playoffs. Most of the violent commercials were advertisements for network programs, cable programs, and cinema releases.

Timothy Crimmins, MD., who recently completed three terms as chair of the MMA Board of Trustees, was interviewed about Anderson's report in the Minneapolis-based *Star Tribune*. "This makes it difficult because the networks continue to promote violent programs in ways that are subtle and influential on children," Crimmins said. "I would hope [the networks] recognize the harm they are causing and reduce this type of advertising during sporting events."

MMA's Unload It & Lock It Still Available

As hunting season begins, the MMA reminds members about the availability of its brochure/poster "Unload It & Lock It: Your Physician's Firearm Safety Checklist." The publication includes crucial safety tips for gun owners and a poster-style checklist for secure storage and safe use of firearms. It has been endorsed by the Department of Natural Resources, Minnesota Conservation Officers, and Attorney General Hubert H. Humphrey III. For more information, or to obtain copies of "Unload It & Lock It," contact Beth Hoheisel at the MMA at 612/378-1875 or 800/342-5662. • • • • •

Project Explores Tobacco Use by Southeast Asian Youth

Special efforts are needed to snuff out tobacco use by Southeast Asian youth in Minnesota. That's the conclusion of a focus group study conducted by the Council for Preventive Medicine, the Asian Business and Community Foundation, and several other organizations representing the Southeast Asian community in Minnesota.

Those organizations came together under the Reducing Tobacco Use Among Asian Youth project. Jill Heins, project coordinator, said that not enough work had been done to examine—and address—unique factors surrounding smoking among Southeast Asian teens. "We realized that this was one of the areas that could use more activity ... that we just don't know a lot about tobacco use in the Southeast Asian community."

Focus groups included Hmong, Vietnamese, Cambodian, and Laotian boys and girls, ranging in age from 15 to 19, and several parents. Among the more interesting findings in the focus group study, Heins said, is that smoking is virtually unheard of among adult Southeast Asian women. Until recently, smoking has been "primarily a male activity—and it starts very young. In Laos or Cambodia, it's not uncommon for 10- and 12-year-old boys to start smoking." One probable reason for this is that many Southeast Asian men and boys are farmers, and smoking helps keep mosquitos away in the fields.

Neal Holtan, M.D., who was a member of the project's advisory group, said the study indicated a cultural gulf between Southeast Asian parents and their teens, who have grown up with many Western values. "The teenagers are Americanized, obviously bi-cultural, and their attitudes reflect that," Holtan said.

Many of the young women in the study pointed to seductive advertising, like that used by Virginia Slims, as a major factor in smoking among their peers. Girls said they were influenced by the "sexy," "sophisticated," and "slim" women shown in the ads.

One doesn't have to be a conspiracy theorist to recognize that tobacco companies have specifically targeted minority cultures to create new customers. Heins said the project team looked at a California study that showed that tobacco billboards appear 17 times more frequently in predominantly Asian communities than in areas that are mostly Caucasian.

Initially, one of the project team's main goals was to work with Southeast Asian merchants in St. Paul's Frogtown neighborhood to reduce or eliminate in-store tobacco advertising and to encourage thorough ID-checking of young cigarette customers.

Since FDA regulations issued last spring were designed to do just that, the project's focus has shifted, Heins said. Now the idea is to help retailers comply with the regulations—which may be more complicated than it sounds. Heins says the regulations are confusing to begin with, and for many merchants, a language barrier makes compliance trickier.

"The FDA regulations were not translated into Southeast Asian languages," Heins said. So in early July, the project team conducted a training for 17 youth leaders, ages 13 to 16, to help translate materials for retailers. The group of Hmong and Vietnamese teen leaders—Teens Against Tobacco Use, or TATU—have gone door to door, talking to merchants about the regulations and why, from a youth perspective, they're important. TATU members also give anti-smoking presentations to peers and younger children in their communities.

Holtan said that from a personal standpoint, as a physician who has many Southeast Asian patients, he would like to see smoking cessation programs made available for youths and adults who want to quit.

The project team's study was funded by a grant from Minnesota ASSIST (Americans Stop Smoking Intervention Study), which is comprised of the state Department of Health and the state chapter of the American Cancer Society. Other groups involved in the project include the Hmong Minnesota Pacific Association, the Association for the Advancement of Hmong Women, and the *Asian American Press*.

• • • • •

Medicare + Choice Rate Increases Are Small in Minnesota's Urban Counties

• • • • • The Health Care Financing Administration has released the 1998 Medicare + Choice rates (formerly adjusted average per capita cost payment, or AAPCC, rates). Rate increases vary from 2 percent in most Twin Cities counties, to a 62 percent increase in Chippewa County. In Minnesota, the average county Medicare + Choice rate is $370.44—a 22 percent hike over the 1997 average rate of $304.32. Medicare legislation passed earlier this year set a minimum payment "floor" of $367. Across the U.S., average county rates range from $369 in Nebraska, which saw a per-county average increase of 22 percent over 1997, to $524 in New Jersey (a spread of $155). This represents a significant step toward equity when compared to last year's figures, in which the average rate was $292 in Nebraska and $513 in New Jersey (a $221 spread).

NEWS BRIEFS

HIV/STD Task Force Seeks New Members

The Commissioner's Task Force on HIV/STD Prevention is seeking 14 new members. The task force meets monthly to develop recommendations for the state on how to prevent the spread of HIV and other sexually transmitted diseases. To obtain an application, or for more information, call Lucy Slater at the Minnesota Department of Health at 612/623-5698. Applications must be received by December 1.

MHDI Completes Clinic Survey Pilot Project

The Minnesota Health Data Institute has completed its survey of 11 Duluth-area primary care clinics. The results of the 1997 Clinic Survey Pilot Project were disclosed to the clinics but not to the public; the project was meant to serve as a model for a similar survey to be completed in 1998. The results of the 1998 standardized survey will be reported to consumers and purchasers for use as a tool in choosing a clinic. According to the Health Data Institute, the participating clinics were pleased with the process and the results of the survey.

HMO Profile is Available

The Minnesota Department of Health's first annual Health Maintenance Organization Profile is now available. The profile reports changes in the state's health care market, and compares performance information from Minnesota's HMOs with Minnesota's public health goals for the year 2000. The profile includes the following findings: More than 40 percent of the state's population is enrolled in an insured HMO, including 60 percent of the Twin Cities population; enrollment in insured HMOs increased more than 13 percent during 1996; and greater Minnesota accounted for three quarters of the increase in total HMO enrollment. To obtain the HMO profile, call the MDH Information Clearinghouse at 612/282-6314.

PSAs Promote Tune Out the Violence Day November 14

Television public service announcements by the MMA and Attorney General Hubert Humphrey III publicize National Tune Out the Violence Day, which this year is Friday, November 14. The PSAs urge parents to set clear limits on television watching and, most importantly, to talk to their children about what they're watching.

Nestlé Magic Pulled Off the Market

Nestlé USA—under pressure from the FDA, the attorneys general of Minnesota and Connecticut, and at least a dozen consumers with safety complaints—announced on October 1 that it was pulling the controversial toy/candy product Nestlé Magic from the market. The MMA, represented by Jeffrey Schiff, M.D., held a news conference with Attorney General Hubert Humphrey III on August 27 to warn parents about health and safety concerns with the product. Schiff, who is medical director of the Emergency Medical Services for Children Resource Center, also represented the American Academy of Pediatrics at the news conference. Nestlé Magic is a chocolate-covered plastic ball containing a small plastic Disney character. A Nestlé spokeswoman told the Associated Press that the Consumer Product Safety Commission is investigating a case in which a child bit into the plastic ball that contains the toy.

HTAC Seeks Applicants for Committee Vacancies

The Health Technology Advisory Committee (HTAC) is seeking applicants for committee vacancies. HTAC was created in 1992 by the state Legislature to provide scientific information on new and emerging health care technologies to policymakers, consumers, and payers.

Application forms may be obtained by calling the Office of the Secretary of State at 612/297-5845. They must be returned by November 25. Selection of new members will be made in December, with new terms beginning January 1, 1998.

Medicare Payment Advisory Commission Named

The U.S. General Accounting Office named the charter members of the Medicare Payment Advisory Commission, or MedPAC, on September 30. MedPAC, created under the Balanced Budget Act of 1997, will advise Congress on Medicare payment policies and other policy issues affecting Medicare and the broader health care system. The commission merges the roles of the Physician Payment Review Commission (PPRC) and the Prospective Payment Assessment Commission (ProPAC), which previously provided Congress with analysis and advice on policy issues affecting parts A and B of the Medicare program. Gail Wilensky, Ph.D., of Project HOPE in Bethesda, Maryland, was named MedPAC chair.

Supreme Court Upholds Oregon's Assisted Suicide Law

• • • • • AS *THE MONITOR* GOES TO press, Oregon voters are deciding, in a mail-in referendum, whether to keep or repeal the state's controversial assisted suicide law.

The United States Supreme Court rejected in October the final appeals of those who had blocked Oregon's assisted suicide law from taking effect—making the state the first to allow physician-assisted suicide.

The Court had ruled in June that the Constitution does not give individuals a "right to die" with medical assistance, but said that the question of assisted suicide was one for states to decide. The Court's latest ruling turned down an appeal of a lower court's ruling dismissing the lawsuit that had kept the law tied up since its adoption in a 1994 referendum.

Under the law, a mentally competent adult suffering from a terminal illness—defined as likely to result in death within six months—may receive two lethal doses of medication after consulting with two doctors and waiting 15 days. It includes provisions meant to ensure that the patient's decision is voluntary and not the result of depression.

The current referendum, which ends November 4, will let voters decide the fate of the Death With Dignity Act. The measure passed 51 to 49 percent the first time. Opponents of the law, who believe it violates the rights of terminally ill people to equal protection, have mounted a $2 million advertising campaign urging voters to overturn it.

MMA Endorses Physician's Guide to Hospice Care

The Minnesota Medical Association has pledged to promote *Hospice Care: A Physician's Guide*, a publication of the Minnesota Hospice Organization. The guidebook has been endorsed by the MMA as a valuable reference for physicians.

The current edition, published in 1995, includes chapters that discuss the physician's role in hospice care, preparing patients for hospice care, utilizing the hospice team, where hospice care is provided, and how hospice care is paid for.

According to the guidebook, one myth surrounding hospice care is that a hospice is a place to "go" to die. The reality is that home is the most common and preferred place for many patients to receive hospice care—although homelike residential hospice care facilities are available in many communities.

The guidebook offers suggestions for delivering difficult news and for initiating a discussion of hospice care. It also anticipates common questions from patients and their families, such as "What about the pain?" and "What should we do next?" Included is a diagram of the "hospice interdisciplinary team," which may include the attending physician, the hospice medical director, a hospice nurse, a social worker, a spiritual adviser, a home health aide, a bereavement counselor, other therapists, and volunteers.

The chapter discussing payment features a useful table with physician billing guidelines for Medicare, and Medicare reimbursement is discussed in some detail in the text.

An addendum, originally published by the National Hospice Organization, includes medical guidelines for determining prognosis in selected non-cancer diseases.

The MMA Committee on Ethics and Medical-Legal Affairs helped edit the first and second versions of the hospice guidebook. To obtain a copy, call the Minnesota Hospice Organization at 612/659-0423.

A third edition of the guidebook is currently being considered. • • • • •

Withheld Treatment, Assisted Suicide Differ

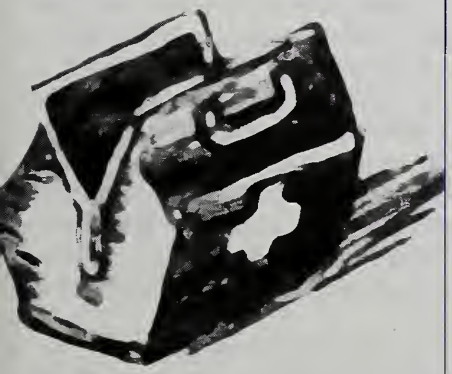
The MMA Committee on Ethics and Medical-Legal Affairs is finishing its educational paper exploring the distinction between withholding or withdrawing treatment and actively assisting suicide, said Patricia Franklin, director of legal affairs for the MMA. Franklin said the paper is intended to provide physicians with a comprehensive review of the positions of the MMA and of other medical organizations, of applicable laws and court decisions, and of the biomedical ethics literature on the subject. If you have any questions, or to obtain a copy of the paper upon its completion, contact Franklin at 612/378-1875 or 800/342-5662. • • • • •

The Monitor
NOVEMBER 1997
• • •
PRESIDENT
Kent S. Wilson, M.D.
CHAIR, BOARD OF TRUSTEES
Paul C. Matson, M.D.
CHIEF EXECUTIVE OFFICER
Paul S. Sanders, M.D.
EDITOR
Lorrie Holmgren
WRITER
Susan Maas
• • •

THE *HARDEST PART* OF FINDING THE RIGHT JOB SHOULDN'T BE FINDING THE RIGHT *JOB postings*







PRACTICE RESOURCES

MINNESOTA'S ULTIMATE MEDICAL PLACEMENT RESOURCE

The ideal physician candidates for your clinic's open positions for physicians are out there, right now, trying to find your job postings. Can they find them?

Just 5 minutes of your time can put your job postings in the hands of over 3,000 physicians each month. It is easy and cost effective with Practice Resources®, a new, Internet and telephone-based regional database of practice opportunities. Just a few minutes of your time spent completing a short form is all that is needed to create an audio script and Internet posting that will generate interest and qualified responses to your posting.

Placement opportunities are accessible nationally by physicians through a toll-free call or the Internet web site. Physicians can quickly search through hundreds of postings by specialty or location. More than 3,000 physicians nationwide use the service each month.

Physicians can respond confidentially by dictating a mini-CV via voice mail or completing an application form online. Candidate responses are faxed to you the next business day.

Practice Resources complements your recruitment strategies and is priced to fit within your budget. Special rates are available for placement in both Practice Resources and *Minnesota Medicine*, the monthly journal of the Minnesota Medical Association. To learn more about the service or to place a position, call David Franz at (888) 884-8241 or complete the attached reply card.

MMBR

MINNESOTA MEDICAL BUSINESS RESOURCES OWNED BY MMA & HMS

Powered By ART

Practice Resources is a joint venture of Minnesota Medical Business Resources (MMBR) and Applied Recruitment Technologies (ART). MMBR is a wholly owned subsidiary of the Minnesota Medical Association and the Hennepin Medical Society.

Hospice Care for Terminally Ill Hmong Patients

A Good Cultural Fit?

Differing beliefs about health practices may lead to misunderstandings between hospice staff and Hmong patients.

Dorothy E. Vawter, Ph.D., and Barbara Babbitt, M.A., R.N.

Mr. L., a 70-year-old Hmong gentleman, has cancer of the face with severe disfiguration. He and his wife have been in the United States for 10 years. They currently live with their son, daughter-in-law, and six other family members. Mr. L. has difficulty speaking, swallowing, and seeing. Although he never mentions pain, his hospice care team is convinced that he is suffering. Hospice staff are disturbed that he rarely uses the pain medications they supply, including Duragesic patches. Mr. L.'s son, with whom hospice staff communicate most, repeatedly expresses deep concern about his father's inability to eat and maintain his strength. Staff members encourage the family to make sure that Mr. L. takes his pain medication and uses the patches, suggesting that pain control may improve his eating.

One evening, after a bad choking episode, Mr. L.'s son and wife brought Mr. L. to the emergency department in a weakened state. The son requested that his father be given a feeding tube. The ED staff admitted Mr. L. for rehydration and pain management. Early the next morning, Mr. L. told a nurse through a hospital interpreter that he did not want any pain medication because it would make him live longer. He said he just wanted to go home.

The hospice philosophy of providing compassionate end-of-life care to patients and their families includes well-developed views about good deaths, pain and pain management, and respectful treatment of dying patients. Culturally diverse clients, such as Mr. L. and his family, often have different beliefs about end-of-life care. How good a fit is hospice care for traditional Hmong patients and families? What aspects of hospice care are likely to be unfamiliar, unintelligible, frightening, or disrespectful to them? Conversely, which traditional Hmong health beliefs and practices are likely to be unfamiliar and challenging to hospice providers?

Our observations about the fit between hospice norms and traditional Hmong health beliefs are based on several collaborative projects involving the Minnesota Center for Health Care Ethics and members of the Hmong community. These projects on ethical issues in cross-cultural health care seek to improve the level of respect and trust between Western health care professionals and Hmong patients and their families. We owe many of the following insights to a series of informal interviews we conducted with Hmong and Western health care professionals in the Twin Cities, as well as a panel discussion of case studies at a recent conference on improving hospice care for Hmong patients.[1] Although this article offers general statements about traditional Hmong values, the Hmong community is very diverse. It is important for health professionals to learn the specific beliefs of each Hmong patient and family they treat.

Health Beliefs Shared by Hmong Patients and Hospice Staff

Several traditional Hmong health beliefs and practices fit well with hospice goals. For example, both groups prefer pain control and preservation of function to risky invasive therapies that intrude upon or threaten bodily integrity. The importance of family support in hospice fits well with the central role Hmong families play in decision-making and caring for sick family members. Both groups also support the open expression of grief by family members and friends after a death. Perhaps most important, Hmong patients and hospice providers share an awareness of, and attention to, the spiritual dimensions of health, illness, and healing.

While these common health beliefs are significant, it would be a mistake to conclude too quickly that hospice care, without adjustment, offers culturally appropriate end-of-life care to terminally ill Hmong patients and their families.

Divergent Beliefs and Practices

Good deaths and bad deaths

In the traditional Hmong world view, dying an unnatural death of any kind, including traumatic, accidental, surgical, and untimely deaths, has serious adverse consequences for both the deceased and the family. The soul of

a person who dies an unnatural death cannot get to the afterlife and stays around to cause problems for the living.

It is also important to die with all one's body parts intact, without obvious scars or disfigurement, and without any metal pieces or staples in the body. Lack of bodily integrity, including pieces of metal in the body, can interfere with the form the body takes upon reincarnation. Dying in the wrong place—far from where one was born, separated from family, or in the home of someone who is not a member of the same clan—is a bad death. Dying alone, without family present to help make decisions and provide care, or dying after prolonged pain and suffering are also undesirable. Finally, it is considered shameful to die in old, dirty, or poor clothing, since it is important to look good when one is reunited with one's ancestors in the next life.

The concept of a "good death" is foreign to the traditional Hmong world view. A "better death" is one in which the person dies quickly, with little pain, at home, feeling deeply loved and respected by his or her family, able to offer last words to family members, able to eat and drink, looking good—without scars or missing body parts—and well-dressed, perhaps in ceremonial costumes.

Being open to these views of good and bad deaths can help hospice staff develop end-of-life care plans that do not inadvertently contribute to the patient's and family's suffering and that are more culturally respectful.

Pain, pain relief, and cure

Just as concepts of good and bad deaths vary across cultures, so do attitudes about pain, expression of pain, and the use of pain remedies.[2] Some Hmong patients consider it shameful to express pain or believe that bearing pain without complaint conveys dignity. Others may express their pain dramatically in an effort to convince people of the seriousness of their illness or possibly in response to the extraordinary hardship and loss they have experienced in their lives. In general, Hmong people interpret pain as a sign of illness but do not consider themselves ill unless they are unable to get out of bed and undertake their daily responsibilities.[3]

Hmong patients may be reluctant to tell a health care professional that they are experiencing pain, either because they expect their pain to be obvious to healers or because pain frightens them and they find it difficult to talk about. They tend to be more indirect; they might say, for example, that they are tired, or scared something bad will happen. It is not unusual for Hmong adults to seek to protect younger members of the family from their pain.

Although Hmong patients generally welcome pain remedies, hospice staff may find that some of their Hmong patients do not take their pain medications. In addition to language barriers that may interfere with communication about what the medicine is for and how it should be taken, Hmong patients tend to believe that Western medications work differently for them and that the medications are either too strong or do not work at all. Many Hmong patients find the side effects of Western medications unacceptable. Others stop taking a medication at the first sign that it does not work. Some Hmong patients, particularly the elderly, prefer smoking opium for pain relief rather than taking slow-acting pills or receiving injections. Since smoking opium is illegal, patients may be reluctant to disclose their use. Finally, some Hmong hospice patients prefer not to pursue pain relief. They feel that if they can tolerate the suffering, this increases their chances that the next life will be better. Other seriously ill Hmong patients, like Mr. L., do not take medication because they think it will prolong their life, and they wish to die.

This latter situation is a key source of confusion and misunderstanding between hospice staff and Hmong patients. While hospice staff seek to relieve patients' pain while not pursuing cures, many Hmong people see pain relief as synonymous with cure. It becomes a distinct challenge for hospice staff to explain the goals of hospice care in ways that support informed decision-making.

Respectful and Compassionate Treatment of the Dying

In sharp contrast to hospice attitudes regarding good death, Hmong people prefer not to talk about death directly or explicitly. Many Hmong persons are offended and frightened by predictions that death will occur. Such discussions are not seen as opportunities for healing; rather, they create emotional distress, which can cause soul loss and ill health. Explicit discussions are also believed to cause evil spirits to bring an early death. Words have magical power, especially when spoken by someone in authority, such as a doctor or nurse. Instead of saying, "Your mother will die tonight," Hmong prefer less blunt messages, such as "Your mother is not doing well"; "She is doing worse today than yesterday"; or "Your family will have a difficult week." Respect and compassion for Hmong hospice clients often means waiving the customary requirement that patients and families explicitly acknowledge that the patient is dying.

In traditional Hmong culture, any behavior that suggests one accepts the pending death of a loved one, such as discussing death directly, not doing everything possible to extend the person's life, planning the patient's funeral, or not pleading with the person to stay in this life, is considered disrespectful and unloving. Moreover, family members fear that if the spirit of a deceased loved one feels less than fully respected, the spirit will trouble family members in the future. Hospice staff may misinterpret family members' behavior toward the dying person as evidence of denial or even cruel or disrespectful treatment.

The hospice practice of requiring patients to refuse life-prolonging interventions is sometimes viewed by Hmong patients and families as disrespectful. Given the discrimination the Hmong have experienced for years in this country, it is not surprising that some Hmong patients, especially those on medical assistance, feel hospice is second-class care for second-class members of American society. These patients are likely to view

hospitals and life-sustaining treatments as the premier care that Western medicine has to offer. Family members may choose life-sustaining interventions, especially for their dying elders, as an expression of deep respect.

Conclusion

Understanding the hopes and fears of terminally ill patients and their families, as well as common misunderstandings and conflicts between one's own cultural practices and those of patients are important aspects of end-of-life care. Our discussion suggests that there is a partial fit between hospice care and traditional Hmong beliefs, but that hospice staff may need to modify some of their practices to achieve their goal of providing respectful and compassionate care to all of their patients. MM

Dorothy Vawter is associate director and Barbara Babbitt is associate for diversity studies at the Minnesota Center for Health Care Ethics in Minneapolis.

Acknowledgments

We are particularly indebted to Dr. Kathie Culhane-Pera, ChueHue Thao, and Mao Thao for generously sharing with us their extensive expertise. We also wish to thank and acknowledge the important contributions of Karen Harrison, Beth Spottiswoode, Sheng Thao, and Deu Yang. No one mentioned here, however, is responsible in any way for errors or omissions, as the responsibility for the interpretations herein remain our own. Generous financial support for this work has been provided by HealthEast Hospice and HealthSpan Hospice, the Medtronic Foundation, and the Partners in Justice Fund of the Sisters of St. Joseph of Carondolet.

References

1. Conference on improving hospice care for Hmong patients and families 1997: May 1. St. Paul, MN. Cosponsored by the Minnesota Center for Health Care Ethics, HealthEast Hospice, and HealthSpan Hospice.
2. Helman CG: Pain and culture. In: Culture, health and illness: an introduction for health professionals, 3rd ed. Oxford: Butterworth-Heinemann, 1994.
3. Thao X: Southeast Asian refugees of Rhode Island: the Hmong perception of illness. Rhode Island Medical Journal 1984;67: 323-9.

FAMILY PHYSICIANS

The University of Minnesota Dept. of Family Practice and Community Health is seeking two physician faculty members—one for its state-of-the-art community residency program clinic affiliated with North Memorial Medical Center, and one for the University residency site. Teaching, administrative, and full-range family practice clinical duties. Attractive benefits package. ABFP, MN license, teaching experience. Call Joseph M. Keenan, M.D., for full description and qualifications, (612) 624-2622, or view our Web page at:

http://www.med.umn.edu/fp/

The University of Minnesota is an Equal Opportunity Educator and Employer.

Park Nicollet Clinic
HealthSystem Minnesota

Urgent Care Department

- BC/BE family practitioners, general internists, or emergency medicine practitioners
- Burnsville, Brookdale, Carlson Center, and St. Louis Park offices
- Varied and challenging patient population
- Flexible scheduling options, all considered full-time with same base pay
  - #1 40 hrs/wk, no evenings/no weekends
  - #2 36 hrs/wk, 6 hrs of evenings/weekends
  - #3 32 hrs/wk, 12 hrs of evenings/weekends
  - #4 28 hrs/wk, 18 hrs of evenings/weekends
- A 411-physician Multispecialty Clinic
- Contact Patric Moylan at 612/993-5986
  or
- Send CV and letters of inquiry to:
  Professional Practice Resources
  Park Nicollet Clinic
  3800 Park Nicollet Boulevard
  St. Louis Park, MN 55416
  or
  Fax 612/993-2819

Physician-Assisted Suicide

The U.S. Supreme Court Weighs In

At the conclusion of its last term, the U.S. Supreme Court determined Americans do not have a constitutional right to physician-assisted suicide.

Patricia L. Franklin, J.D.

In two recent and highly publicized cases, the U.S. Supreme Court considered the constitutionality of two state laws that prohibit assisted suicide. The court refused, at least for now, to recognize a right to assisted suicide.[1,2]

The cases involved laws in the states of Washington and New York. In both states, as in most of the United States, it is a crime to assist a suicide. Violations of Washington's law constitute a felony punishable by up to five years in prison and a fine of up to $10,000.[3] In New York, assisting suicide is a felony charged as manslaughter in the second degree.[4]

Washington v. Glucksberg

Washington v. Glucksberg[1] was originally brought by four physicians, three terminally ill patients, and a nonprofit organization called Compassion in Dying. The physicians claimed that they sometimes treated terminally ill, competent adults who expressed a desire to hasten their deaths with the help of a physician. Each of the patients suffered from what proved to be the final stages of a terminal illness. One patient was suffering from cancer that had metastasized throughout the skeleton. The second was suffering from AIDS and a number of related infections, and the third was debilitated by emphysema. All three patients died after the start of the litigation, but before the filing of the Supreme Court action.

At the heart of their claims, these physicians and patients alleged that the Washington law violated the due process clause of the 14th Amendment of the Constitution as applied to terminally ill, mentally competent adults who wish to end their lives with the help of medication prescribed by their doctors. In other words, they did not challenge the Washington law in its entirety, only the provision prohibiting competent patients from seeking the help of physicians to end their lives.

The 9th U.S. Circuit Court of Appeals agreed.[3] Specifically, the Court of Appeals found a constitutionally protected fundamental liberty interest in the choice of how and when one dies. It determined that the Washington law violated that interest when applied to competent, terminally ill adults wishing to hasten their deaths with medication prescribed by physicians.[3]

On review, the U.S. Supreme Court disagreed.[1] In a unanimous judgment (with five of the nine justices concurring but writing separate opinions), the court held that Washington's ban on assisting suicide does not violate the Constitution. The court refused to recognize a right to commit suicide or to seek assistance in doing so.

In writing the opinion for the court, Chief Justice William Rehnquist first narrowed the issue for review. The Washington statute prohibited aiding another person to attempt suicide. That being so, Rehnquist reasoned that the question for review was whether the liberty interests protected by the due process clause of the Constitution include a right to commit suicide, with a right to assistance in doing so. Traditionally, wrote Rehnquist, the Supreme Court has ruled that the due process clause extends to a number of liberty interests that are protected against government interference absent the most compelling reasons. These liberties include the right to marry, procreate, direct your child's education and upbringing, enjoy marital privacy, use contraception, maintain bodily integrity, and secure an abortion. However, the opinion pointed out, the court has been careful to extend constitutional protections to an asserted right or interest. Such an extension requires showing both that the asserted interest is deeply rooted in our country's history and tradition and is capable of narrow and careful description, "lest the liberty protected by the Due Process Clause be subtly transformed into the policy preferences of the members of this Court."[1]

The opinion reasoned that neither showing can be made in this case. In fact, rather than a long tradition favorable to assisted suicide, we have a history of criminalizing both suicide and assisting suicide, a history Rehnquist reviews extensively in the opinion. Thus, the court declared itself "confronted with a consistent and almost universal tradition that has long rejected the asserted right, and continues to explicitly reject it today, even for terminally ill, men-

Physician-Assisted Suicide Is Not a Good Option without Decent, Universal Health Care

Arthur Caplan, Ph.D.

America is not ready for legalized physician-assisted suicide, argued bioethicist Arthur Caplan, Ph.D., guest speaker at the 1997 Milton G. Ettinger Lecture at Hennepin County Medical Center in September. "I have reservations about the wisdom of changing the law at the present time, although I'm not an absolute opponent of all assisted suicide cases," he said. Director of the Center for Bioethics at the University of Pennsylvania Medical Center and former head of the Center for Biomedical Ethics at the University of Minnesota, Caplan has been actively involved in the national debate over physician-assisted suicide and other medical-ethics issues.

American society has come to a consensus that "self-determination" in medical treatment is legal and even encouraged, said Caplan. The competent, informed, comprehending adult may refuse or stop medical treatment, for whatever reason, at any time. A long history of bioethical cases debated over the last 40 years, the first of which occurred before bioethics even emerged as an academic field, established this right.

"We [value] self-determination, personal autonomy, freedom from unwanted intrusion, and choice. So why wouldn't we take the last step and say, 'Well, hastening your death with the assistance of a doctor is self-determination'? Why isn't that the natural consequence?" asked Caplan.

"I'll tell you why," he continued. "To make a choice, we must have options and freedom from coercion. In our society, we have two obstacles to choice."

First, he pointed out, about 20 percent of Americans have no health insurance. "You cannot argue a right to be killed by your doctor before you've established the right to be treated by a doctor. It is not wise to offer the option of assisted dying when some patients think [health care providers] don't like the color of their skin or the size of their wallets. Many patients fear they will not be given a choice."

Second, said Caplan, before legalizing assisted suicide, we need to guarantee humane care at the time of death—at least as an option. Basic hospice and decent, affordable long-term care are not readily available. "We have many good nursing homes and heroes working in chronic and long-term care, but we also have too many lousy long-term care facilities. Many people fear they will wind up in a roach-infested, urine-stained bed, with no one to talk to, indifferent care, and going broke in the process. That is not choice. We can ask, 'Would you like to go there, or would you like to hurry your death?' Personally, I'd pick death. I don't want to die in some back ward, left alone by strangers, wired to some goofy technology, neglected. Who would?"

If we legalize assisted suicide today, we will never overcome these obstacles, argued Caplan.

He also pointed out that most people will not need assistance in dying. They will manage their dying as they want to, where they want to. Society's fight for self-determination has given people the right to control their lives and their deaths. "We have carved out a large array of freedom, or the ability to articulate what you want—even if you can't speak—through the living will and the selection of a decision-maker. Americans don't have to fear they will be trapped by treatment they don't want, forced to suffer in ways they find unacceptable, put through pain and misery in a death they don't like. We've reached a lot of consensus, short of assisted suicide." However, Caplan continued, we haven't successfully educated the public and health care providers about these options.

In concluding, Caplan emphasized that the call for physician-assisted suicide is primarily a result of our health care system's shortcomings. "If we had not made such a hash of dying, if we had not left people in pain, if we had not constructed a system with no time to talk, if we *had* put any continuity of care into the health care system, we wouldn't have people trying so vigorously to escape it. What leads people to want assisted suicide? They don't want to die amid strangers. They don't want to die incompetent. They don't want to die mentally incapacitated. They *would* like to have some conversation, some ability to communicate and talk about their situation. They would like some spiritual support. Does our health care system do a good job in these areas? No."

The 1997 Milton G. Ettinger Lecture, held September 8, was sponsored by the Hennepin County Medical Center Department of Neurology. Milton Ettinger, retired HCMC chief of neurology, became the first full-time neurologist at HCMC in 1961. Appointed chief in 1963, he led the department for more than three decades. He is regarded as a skilled physician, committed educator, and natural leader.

tally competent adults."[1]

In their briefs to the court, the physicians and patients argued that the liberty interest they were asking the court to recognize was consistent with the court's earlier due process rulings, even if it was not consistent with history and tradition. To support their claim, they relied on the court's opinions in the cases *Cruzan v. Director, Missouri Department of Health*[5] and *Planned Parenthood v. Casey*.[6]

Citing *Cruzan*, the physicians and patients argued that the court had acknowledged competent, dying persons have a right to direct the removal of medical treatment, including nutrition and hydration by artificial means, to hasten their deaths. They argued that the choice to hasten death by consuming lethal does of medication is a natural extension of that right.

In *Casey*, the court reaffirmed the holding in *Roe v. Wade*.[7] In reaching its conclusion in *Casey*, the court discussed the long line of cases that protect the personal liberties discussed above, noting that they "involve the most intimate and personal choices a person may make in a lifetime."[1] The physicians and patients contended that the decision to hasten one's death was among this category of intimate and personal choices that should not be proscribed by the state.

The Supreme Court, however, rejected both of these arguments. With regard to *Cruzan*, the court went to great length to distinguish the right to refuse medical treatment from the right asserted in this case and refused to be persuaded that the same legal protections should be accorded to both. With regard to *Casey*, the court maintained that even though the decision of how and when one is to die is of a personal and intimate nature, not all important personal choices must be accorded constitutional protection.

The remainder of the court's opinion addressed the relationship that Washington's prohibition of assisting a suicide bears on the state's interest in protecting its citizens. In any case arguing a violation of the due process clause, once the court has reasoned that the personal interest at stake is not "fundamental," the state need only persuade the court that its law affecting that interest is rationally related to a legitimate government purpose. According to the court, that test is easily satisfied, and the opinion discusses five separate legitimate state interests supporting the ban: Washington's unqualified interest in preserving human life; the interest in preventing suicide; the interest in protecting the integrity and ethics of the medical profession (relying in part on the arguments asserted by the American Medical Association in an amicus curiae brief); the interest in protecting vulnerable groups, including the poor, the elderly, and the disabled from abuse, neglect, and mistakes; and the fear that permitting assisted suicide would start the state down a path toward voluntary or even involuntary euthanasia. Thus, the court concluded that Washington's ban on assisted suicide did not violate the due process clause of the Constitution, either on its face or as applied to competent, terminally ill adults seeking to hasten their deaths by obtaining medication prescribed by their doctors.

Vacco v. Quill

As in *Washington v. Glucksberg*, physicians and their terminally ill patients initiated the case of *Vacco v. Quill*.[2] The three physicians contended that in the course of their practices, they encountered mentally competent, terminally ill patients who, because they were suffering, sought to hasten their deaths with the assistance of their physicians through the prescription of lethal medications. The physicians contended that they could not exercise their best professional judgment—to assist their patients in this fashion—because New York state law prohibited individuals from assisting another in committing suicide.[8]

The three patients contended that they understood they were in the final stages of a terminal illness and had no chance of recovery. They all expressed a desire to end their lives with prescription medications they would self-administer.

These physicians and patients argued that the state law prohibiting assisted suicide violated both the due process and equal protection clauses of the 14th Amendment. As stated earlier, the due process clause protects certain fundamental personal liberty interests from unwarranted government interference. The equal protection clause requires the government to treat in a similar manner all individuals who are similarly situated. The first court to hear this case was the U.S. District Court for the Southern District of New York, which rejected both claims.[8]

On appeal, the 2nd U.S. Circuit Court of Appeals[4] agreed that the state law did not violate the due process clause but determined that it did violate the equal protection clause. It reasoned that because New York law does not similarly treat all competent persons in the final stage of fatal illness who wish to hasten their deaths, and because the difference in treatment lacked a legitimate purpose, the law must be struck down. Specifically, because New York law allowed competent adults to hasten their deaths by ordering the removal of life-support systems and other treatment, the same law must allow competent adults to hasten their deaths by seeking assistance in committing suicide.

Again, with all nine justices concurring, the Supreme Court rejected this conclusion and found no violation of the equal protection clause. While acknowledging that the clause requires states to treat similar cases alike, the court also noted that states are free to treat unlike cases differently. In that regard, and contrary to the 2nd Circuit, the Supreme Court refused to accept the notion that refusing unwanted medical treatment is tantamount to seeking assistance in committing suicide. Because these choices are fundamentally different, a law upholding the right to make one, while prohibiting the other, applies evenhandedly and "unquestionably complies" with the equal protection clause.[2]

Chief Justice Rehnquist again penned the court's opinion, noting that the distinction between these decisions "comport(s) with fundamental legal principles of causation and intent."[2] Refusing life-sustain-

Is A Well-Established, Highly Respected Multispecialty Practice And Family Values Important To You?

We Thought So!

That's why there's The Monroe Clinic. Sponsored by the Sisters of St. Agnes, we actively promote our healing mission with care and compassion for our staff, patients and their families, support community education towards healthy lifestyles, respect human dignity and value individual talents, efforts and teamwork with mutual respect.

- Child Psychiatry
- Dermatology
- Family Practice
- Cardiology
- Internal Medicine
- Ophthalmology

The Monroe Clinic is an integrated health care facility comprised of a 114,000 sq. ft. clinic, an adjacent acute care hospital with 24 hour ER coverage, and seven branch clinics. Serving the residents of southern Wisconsin and northern Illinois for over 50 years, we have grown to 70+ physicians practicing over 25 different specialties.

If you want to practice cutting - edge medicine in one of America's "best small towns", you can find it here, today, at The Monroe Clinic in Monroe, Wisconsin. If you're a BC/BE Physician, please send CV, write or call: Physician Staffing Specialist, **THE MONROE CLINIC**, 515 22nd Avenue, Monroe, WI 53566. Call 1-800-373-2564. FAX# (608) 324-2469. EOE.

The Monroe Clinic
A proud caring tradition

Not eligible for J1 Visa employment

North Central Medical Conference
Presents Exciting Trips From Minneapolis/St. Paul



China - Yangtze River Cruise

Program A - March 27 - April 7, 1998 $2,599
Program B1 - March 21 - April 4, 1998 $3,159
Program B - March 23 - April 6, 1998 $3,099
Per person, double occupancy. (Plus taxes.)

A wonderful introduction to the Orient!



Grand Capitals of Eastern Europe

Germany, Poland and the Czech Republic
April 14-24, 1998 • April 23 - May 3, 1998
May 2-12, 1998 • May 11-21, 1998
$2,145 Per person, double occupancy. (Plus taxes.)

Down came the "Wall" in November 1989. **Berlin** is now brimming with excitement. **Warsaw**, Poland's proud capital and **Krakow** hometown of Pope John Paul II. **Prague**, the "jewel in the crown of the world."



Luxury Alaskan Cruise On Board the mv Mercury

June/July 1998

Details available in December. Northbound or Southbound Glacier Cruise itinerary. Pre-and post-cruise tours available to Denali National Park, Fairbanks, Anchorage and more!

AVAILABLE TO MEMBERS, THEIR FAMILIES AND FRIENDS.
For additional information and a color brochure contact:

GLOBAL HOLIDAYS
9725 Garfield Avenue South, Minneapolis, MN 55420-4240
(612) 948-8322 Toll Free: 1-800-842-9023

ing medical treatment may lead to death, but the cause of death is the underlying disease. However, when a patient takes a lethal dose of medication, the patient's death is caused by the drug.

Specifically, when a physician withdraws medical treatment from a patient, that physician intends to honor a patient's wish and cease useless and futile treatment. In contrast, when a physician assists a patient's suicide by prescribing medications, the physician "must, necessarily and indubitably, intend primarily that the patient be made dead."[2] In light of this distinction, New York law can treat the decisions differently and not violate the Constitution.

Conclusion

Members of the public on either side of the assisted suicide issue eagerly awaited the decisions in *Washington v. Glucksberg* and *Vacco v. Quill*. In refusing to recognize a constitutionally protected right to assisted suicide, the U.S. Supreme Court signaled a preference that, for now, the debate is best "entrusted to the 'laboratory' of the states."[9] However, the issue will likely come before the court again in a case or cases that more narrowly articulate the issues at stake. MM

Patricia Franklin is the director of legal affairs at the Minnesota Medical Association.

REFERENCES

1. Washington v. Glucksberg, __US__,117 S.Ct. 2258, 138 L.Ed. 2d 772 (June 26, 1997).
2. Vacco v. Quill, __US__, 117 S.Ct. 2293, 138 L.Ed. 2d 834 (June 26, 1997).
3. Compassion in Dying v. Washington, 79 F.3d 790 (9th Cir. 1996).
4. Quill v. Vacco, 80 F.3d 716 (2nd Cir. 1996).
5. Cruzan v. Director, Missouri Dept. of Health, 497 U.S. 261 (1990).
6. Planned Parenthood v. Casey, 505 U.S. 833 (1992).
7. Roe v. Wade, 410 U.S. 113 (1973).
8. Quill v. Koppel, 870 F. Supp. 78 (S.D.N.Y. 1994)
9. Washington v. Glucksberg and Vacco. New York (O'Connor, J. concurring).

A Buying and Leasing Program With Special Benefits

- One stop shopping by FAX
- Buy or lease
- Choose any make or model
- Car or truck
- New or used
- Save time
- Save money
- Eliminate shopping frustration

Remember, whether you purchase or lease, MMBR Motor Services and Creative Leasing, Inc. will help you get the most vehicle at the best price. We'll even help you sell your old auto.

Use your money wisely. For personal attention and lease or purchase information on any vehicle, call 612/623-2860, or toll-free 800/298-MMBR.

MMBR Motor Services is a service of Minnesota Medical Business Resources, a physician-owned corporation of your medical association.

New Vehicle Leases**

Make/Model	MSRP	Your Price*	24 Mo	36 Mo	48 Mo	60 Mo
98 Chevrolet Blazer LS 4dr	$27,847	**$25,476**	$452	$388	$346	$327
98 Ford Explorer XLT 4dr	$28,210	**$25,531**	$476	$407	$360	$330
98 Nissan Pathfinder SE	$30,618	**$28,268**	$506	$440	$409	$375
98 GMC Yukon SLE 4dr	$33,481	**$31,200**	$480	$419	$386	$364
98 Chevrolet Tahoe LS 4dr	$32,862	**$30,652**	$474	$413	$380	$359
98 Chevrolet Suburban 1/2 LS	$36,048	**$33,364**	$552	$458	$415	$388
97 Toyota 4-Runner SR5 4dr	$31,643	**$30,305**	$579	$477	$417	$384
98 Jeep Gr. Cherokee Laredo 4dr	$28,340	**$26,227**	$522	$424	$368	$349
98 Ford Expedition XLT 4dr	$31,640	**$29,083**	$461	$396	$359	$339

Effective date 10/15.
* Sale price before tax, license, and license fees.
** All lease payments listed above are monthly lease payments before tax on factory ordered leases. These lease payments are based on a $0.00 cap reduction and 15,000 miles/year. The only moneys needed to start the above leases are first payment, security deposit, and license for the first year.
*** Note 98 Toyota prices not available yet.



MMBR
MOTOR SERVICES
MINNESOTA MEDICAL BUSINESS RESOURCES
OWNED BY MMA & HMS

Choices at the End of Life

An Annotated Bibliography

Spurred by the assisted suicide debate, death has hit the bestseller list. Here is a random sampling of recently published writings about physician-assisted suicide and end-of-life issues.

Charles R. Meyer, M.D.



Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder

Wesley Smith (Times Books, 1997)

Written by a lawyer who starts with the story of a bungled assisted suicide, *Forced Exit* is a sometimes polemical attack on the premises of physician-assisted suicide (PAS) and euthanasia. Wesley Smith sees the PAS movement as a response to a breakdown in societal connectedness—as autonomy run amok. He considers "death fundamentalists" like the Hemlock Society's Derek Humphrey (whose book *Final Exit* Smith's title parodies) obsessed with death. Smith warns that abuse and exploitation are inherent in the euthanasia movement: "Once we accept the idea that some lives are not worth living, once we come to see the intentional ending of lives of the profoundly disabled as proper, once we claim the right to judge who should live and die on the basis of subjective standards such as happiness, quality of life, or dignity, we have created a disposable caste."



Seduced by Death: Doctors, Patients, and the Dutch Cure

Herbert Hendin (W.W. Norton, 1997)

Herbert Hendin, a professor of psychiatry at New York University and executive director of the American Suicide Foundation, asks: "Does our need to care for people who are terminally ill and to reduce their suffering require us to give physicians the right to end patients' lives?" With a resounding no, he proceeds to counter the arguments of PAS proponents. To the suggestion that PAS will clarify physician roles, he responds that euthanasia is likely only to help physicians deal with the frustration of facing diseases without cures. For supporters of the Dutch experience, he offers tales of assisted death without patient consent, without outside consultation, or in incompetent patients. "In the name of an illusory and self-righteous compassion for the patient, the decisive role of the physician's needs and values in the decision for euthanasia remains concealed," Hendin writes. "Instead of expanding patients' choices, euthanasia becomes a seemingly simple solution for a myriad of problems."



The Wheel of Life: A Memoir of Living and Dying

Elizabeth Kubler-Ross (Scribner, 1997)

Nearly 30 years ago, with her landmark book *On Death and Dying*, Elizabeth Kubler-Ross changed people's thinking about death. *The Wheel of Life,* described as her "last book" since she is paralyzed and anticipating her death, is a fascinating and tragic memoir. Kubler-Ross writes candidly about her Calvinist Swiss childhood, medical school, her default choice of psychiatry, book-propelled fame, disillusionment and divorce, a not-yet-extinguished romance with channeling and spiritualism, and her confrontation with her imminent death. Ironically, she has not found the acceptance she described as the desired end for terminal patients in *On Death and Dying.*



Denial of the Soul: Spiritual and Medical Perspectives on Euthanasia and Mortality

M. Scott Peck (Harmony, 1997)

This bestseller-list denizen laces his case against PAS with anecdotes and distracting frequent references to his own work. M. Scott Peck's psychiatric and religious roots anchor his beliefs: emotional pain is inevitable and frequently treatable; dying is a natural part of life, and denial of death is unhealthy; death can be a learning experience. He describes euthanasia as a "profoundly secular phenomenon" spawned by a consciousness in which a person believes he or she is the center of the universe. "I do regard suicide as a sin," he writes. "Specifically the sin of arrogance." The title of the book points to Peck's approach to death: "The choice of euthanasia generally represents a denial of the soul, a rejection of its creator and her timing. The converse is also true. The choice of a natural death may represent an act of co-creation with God."

A Midwife through the Dying Process: Stories of Healing and Hard Choices at the End of Life

Timothy Quill (Johns Hopkins, 1996)

In nine stories about dying patients, Quill reiterates and embellishes themes that he first articulated in his 1994 book *Death and Dignity,* such as nonabandonment of the patient. He brands as "illusion" the "notion that all requests to physicians for assisted death stem from undertreated pain, unrecognized depression, or some kind of character flaw." He encourages physicians to share their medical expertise while patients share their inner selves. He gives some wise bedside advice on breaking bad news: "Go slowly, allowing the patient to control the depth and focus of the interaction ... the primary goals of an initial encounter include achieving a common perception of the problem, addressing immediate medical risks, responding to pressing discomforts, ensuring a basic plan for follow-up, and, above all, minimizing isolation and aloneness."

Unlike Peck, Quill doesn't see dying as a chance for psychological growth, although he does acknowledge the possibility of ne0w forms of fulfillment. He issues 11 challenges to medicine, including providing comfort care, fostering open discussion, giving patients choice and control, and educating MDs about options like terminal sedation. His lays down a broad gauntlet to modern medicine: "to help [patients] find death when continued living becomes excruciating in spite of our best efforts to comfort them."

Signs of Life: A Memoir of Dying and Discovery

Tim Brookes (Times Books, 1997)

Tim Brookes, a regular NPR commentator, has written a lyrical memoir of his mother's terminal illness. He sketches a historical perspective on the change in doctors from handholders to fighters and in the public from passive acceptors of death to angry blamers. Calling death a drama molded by the psyches of the dying and their loved ones, he charts his emotions through his mother's illness, concluding that finding and showing those strong emotions may be the point of life itself.

Dying Well: The Prospect for Growth at the End of Life

Ira Byock (Riverhead Books, 1997)

Like many of the authors, Ira Byock first encounters death at the loss of a parent. His book contains 11 end-of-life tales, starting with his father's. As a hospice clinician, Byock tries through skilled listening to guide his patients to end-of-life discoveries, a new sense of dignity, and, eventually, acceptance. "Even as they are dying, people retain a capacity for change and growth," Byock writes.

Physician-Assisted Suicide

Robert Weir, editor (Indiana University Press, 1997)

Edited by Robert Weir, director of the Program in Biomedical Ethics and Medical Humanities at the University of Iowa, this collection of 10 multi-authored articles is arranged in five broad topics: historical interpretations; ethical assessments and positions, medical practices and perspectives, potentially vulnerable patients, and public policy options and recommendations. Issues covered include conceptual confusion about what PAS is, disagreement about whether PAS is morally different from stopping life-sustaining treatment or acts of voluntary euthanasia, the conditions acceptable to be considered for PAS (cancer, AIDS, ALS), physician attitudes, and public attitudes toward PAS and physicians who participate in PAS. Nationally renowned writers, including Daniel Callahan and Minnesotans Steven Miles and Susan Wolf, contribute insightful essays.

Whose Right to Die?

Ezekiel Emmanuel (*The Atlantic,* March 1997)

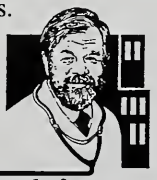
Ezekiel Emmanuel, a professor at Harvard, challenges PAS by exploding four myths, such as "pain is the most common reason for assisted suicide requests." He disputes the idea that the Dutch experience demonstrates how PAS can work by looking at the Remmelink report covering 3,600 cases, including 1,000 involuntary deaths by euthanasia—some of them newborn deaths. He also quotes the Dutch minister of health, who describes euthanasia as the only way to "heal" some patients. He warns that introducing PAS in a country with nonuniversal health care coverage could lead to euthanasia for financial reasons. MM

Charles Meyer is editor-in-chief of Minnesota Medicine *and an internist with Consultants–Internal Medicine in Minneapolis.*

Weigh The Facts!

Benefits to clinics, hospitals and practitioners include:
-Large pool of seasoned physicians.
-Integral part of medical referral network.
-Current in medical care policies, procedures and protocol.

To physicians of all specialties:
-Confidentiality prioritized.
-Financial incentives.
-Medical malpractice.
-Personalized service tailored to your needs.



Whitesell
Medical Locums, Ltd.

Eight First Avenue South
Buffalo, MN 55313
1(800) 876-7171
1(800) 295-6373
Local 682-5218 or 682-5906
FAX (612) 682-4791

People and Places Making Medical News

People

MHHP Elects Officers

The Minnesota Hospital and Healthcare Partnership ratified the nomination of **James Hanko**, chief executive officer of Weiner Memorial Medical Center, as chair-elect of the association. In 1998, he will succeed current chair-elect **Brock Nelson**, CEO of Children's Health Care. Nelson begins his term as chair in January.

MHHP also approved the nomination of secretary/treasurer **James Reinertsen M.D.**, CEO of HealthSystem Minnesota; directors-at-large **James Hanko** and **Raymond Christensen, M.D.**, of Gateway Family Health Clinic in Moose Lake; and trustee directors **Michael Fay** of Fairview Health System in Hibbing and **George Winn, D.D.S.**, of Queen of Peace Hospital in New Prague.

CEO Named for New Red Wing Health Organization

Scott Wordelman has been selected as chief executive officer of Fairview Lakes Regional Health Care, a new organization in Red Wing being formed by the merger of River Region Health Services, Interstate Medical Center, and Fairview Health Services. As *Minnesota Medicine* goes to press, final approval of the merger by the boards involved is pending.

Since 1994, Wordelman has led Fairview Lakes Regional Health Care, which serves people in Rush City, Lino Lakes, Chisago City, North Branch, Wyoming, and Forest Lake. Wordelman will split his time between the Lakes and Red Wing regions until mid-March, when he will lead the Red Wing region full time.

The CEO of Interstate Medical Center, **Bob Schulenberg, M.D.**, will continue his pediatric practice at the medical center. The president and CEO for River Region Health Services, **Wally Sundberg**, plans to take early retirement and set up a health care consulting practice.

The new organization plans to build a hospital/clinic facility in Red Wing to be named Fairview Red Wing Medical Center. The current Interstate clinics will be called Fairview Ellsworth Clinic, Fairview Zumbrota Clinic, and Fairview Red Wing Downtown Clinic.

Places

HealthEast May Keep St. Joseph's Open

HealthEast is re-evaluating its decision to shut down St. Joseph's Hospital in the year 2000 following concern expressed by physicians that the closing could cause a "bed crisis" in downtown St. Paul. Keeping the 290-bed hospital open could save 1,000 jobs.

When HealthEast decided to close the hospital last year, St. Paul was experiencing a business shortage. At the time, the hospital said it had too few patients, about 160 per day. That number recently increased to about 200 patients. HealthEast is conducting a study, expected to be completed by December, to determine whether the hospital should stay open.

Fairview Acquires Savage Family Practice Clinic

Fairview Health Services has acquired the former Sundance Medical Clinic in Savage, located at 4011 West Highway 13. The clinic, now called Fairview Savage Clinic, is staffed by family practitioners **Thomas Nordahl, M.D.**, and **Albert Salazar, M.D.** Fairview Savage Clinic is also home to the Institute for Athletic Medicine, operated by Fairview Health Services and North Memorial Health Care.

Socioeconomics

State Will Help Cover Hospitals' Lost Federal Funds

Minnesota hospitals face an $85 million loss in federal funding over five years because Congress inadvertently used a preliminary report from the Minnesota Department of Human Services that underestimated state Medicaid expenditures. Under state law, Minnesota will issue stopgap funding to cover the first year, about $17 million, which will come from the general fund. After that, hospitals must wait to see whether Congress will correct the error. Even if Congress fixes the mistake, the state should expect reductions of as much as $20 million over five years under the Balanced Budget Act.

Large Clinic Pulls Business from Farmington Hospital

River Valley Clinic, the largest clinic in Farmington, has decided to stop sending patients to the town's hospital, South Suburban Medical Center. The clinic, which provides 60 percent of the South Suburban's business, said it is sending patients to Fairview Ridges Hospital in Burnsville because of patient desires and the need for a broader range of services.

Bob Johnson, chief executive at South Suburban, expressed frustration that the clinic is taking business away from the community. However, River Valley physician **Stuart Menaker, M.D.**, said many patients would not use that clinic because it only admitted to South Suburban. He said Fairview offers broader

services, such as more staff specialists, more birthing rooms, perinatal care, and 24-hour respiratory care coverage.

Rates, Trends, Data

Minnesota Is Once Again Healthiest State in the Nation

Minnesota has once again been named healthiest state in the nation in a comprehensive ranking by Minneapolis-based ReliaStar. It has won the title four of the last seven years, coming in second place the other years. The other top states include New Hampshire, Hawaii, Massachusetts, and Wisconsin. Mississippi and Louisiana tied for the least healthy states, followed by New Mexico, Nevada, and West Virginia.

The rankings compare the states in 17 categories that measure disease, lifestyle, access to health care, occupational safety and disability, and mortality. Minnesota finished in the top 10 states in nine of the 17 categories. These include low smoking rates, low motor vehicle deaths, good high school graduation rates, low unemployment, good access to primary health care, support for public health care, low heart disease rates, low infectious disease rates, low total mortality, and low premature death.

The state's rankings were worse for adequacy of prenatal care, limited activity days (the average number of days in the past month that a person cannot perform work or household tasks due to physical or mental illness), and infant mortality.

CDC: Nation's Health Improving

The CDC's latest vital statistics report is a "wealth of good news," said Health and Human Services Secretary Donna Shalala: Life expectancy has reached an all-time high while infant mortality has hit a record low; AIDS-related deaths, homicides, suicides, and teen pregnancy are all down.

In 1996, the average American could expect to live 76.1 years, up from 75.8 in 1995. The gap in life expectancy between whites and blacks has narrowed, although whites can still expect to live more than six years longer.

Infant mortality dropped to 7.2 deaths per 1,000 live births, a new low. Health officials said the drop is due in part to a 15 percent decrease in deaths from sudden infant death syndrome.

The Perfect Fit...

...is a rare find. Fairview Health Services represents a wide spectrum of practice and lifestyle options in Minnesota. We will help you locate opportunities that are tailored to fit your needs in communities that match your size.

Opportunities now available in communities large, medium and small (and sizes in between) for...

- **Family Practice**
- **General Surgery**
- **Internal Medicine**
- **Obstetrics/Gynecology**
- **Occupational Medicine**
- **Ophthalmology**
- **Orthopedic Surgery**
- **Physical Medicine/ Rehabilitation**
- **Urgent Care**
- **Urology**

Fairview

Physician Recruitment & Retention Dept.
2450 Riverside Avenue
Minneapolis, MN 55454



(800)842•6469 or (612)672•2288 • E-mail: dgustaf1@fairview.org

Emergency Physicians

BE/BC Emergency or Family Practice physicians are needed for the ED at St. Francis Hospital in Shakopee, a southwestern suburb. Full benefits provided.

Urgent Care Physicians

Opportunities available for Urgent care in Shakopee and Chaska, looking for Family Practice and Internal Medicine with pediatrics experience. Permanent part-time and moonlighting positions available, evening and weekend hours.

For Additional Information:

Debbie Modder
Allina Health System
Route 80775
5601 Smetana Drive
Minnetonka, MN 55343
612-992-3094 / 800-248-4921
Fax: 612-992-3669

Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Occupational Health
Ob/Gyn
Pediatrics

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES

The AIDS death rate for 1996 fell to 11.6 deaths per 100,000 people, down from a rate of 15.6 in 1995. For adults between the ages of 25 and 44, the rate fell to 27.2 deaths from 36.9 deaths in 1995.

The homicide rate dropped from 9.4 homicides per 100,000 in 1995 to 8.4 in 1996, and the suicide rate fell from 11.2 to 10.8.

The rate of teens giving birth dropped for the fifth straight year, from 56.8 per 1,000 births in 1995 to 54.7 in 1996 for 15- to 19-year-olds.

National Survey Finds One in Four Girls Has Been Abused

As many as one in four girls has been sexually or physically abused or forced by a date to have sexual intercourse against her will, according to a national survey by the Commonwealth Fund. These girls are more likely to show signs of depression and to engage in risky health behaviors, including dangerous eating habits, smoking, drinking, using drugs, and failing to use contraception. The study, which surveyed 6,748 girls and boys in grades five to 12, found that most perpetrators of abuse were family members or family friends. The abuse usually took place at home and occurred more than once. Instead of defining abuse, the survey left it to the participants to decide what constituted physical or sexual abuse.

"Although these rates are stunningly high, they're very consistent with what we've seen in earlier studies in several states," said **Robert Blum, M.D., Ph.D.**, chair of the Adolescent Health Department at the University of Minnesota, in a *New York Times* article. "The association between abuse and other problems is so striking that all of us in the education and health systems must have our antennae up about abuse whenever we see a kid who isn't functioning well."

The survey also found that one in four girls exhibited symptoms of depression, a rate 50 percent higher than for boys. One in three high school girls had thought about suicide in the past two weeks. African-American girls exhibited fewer signs of depression than white, Asian-American, and Hispanic girls.

Abuse was less common among boys. Nonetheless, 12 percent of high school boys and 8 percent of boys in the fifth to eighth grades said they experienced physical abuse.

Law & Policy

City Can't Screen Medical Records of all Public Housing Applicants

A federal judge has told Minneapolis it cannot investigate the medical records of everyone who applies for public housing, and it may not deny housing to people based on a distant history of drug abuse. Minneapolis requires applicants to allow the city to view their medical records as a way of determining which applicants might disrupt the lives of tenants by bringing in criminal activity.

U.S. District Judge **James Rosenbaum** wrote that he had to reconcile federal laws: a 1996 law that allows inquiries into past drug abuse and others that forbid housing authorities to discriminate against people with disabilities (ex-drug abusers are considered disabled). He determined that the city's actions have exceeded its authority under the 1996 law and violate the antidiscrimination laws. He explained that officials can ban current drug abusers from public housing, but the city must not discriminate against those who have solved a drug problem. Congress intended to ban those who pose a real problem, he said, but not to allow "a blunderbuss inquiry into every housing applicant's medical records."

St. Paul Police to Videotape Domestic Assault Scenes

St. Paul police have begun an experimental new program to document domestic assault cases

on videotape in St. Paul's east side, where the majority of St. Paul's domestic violence cases are reported. For the one-year pilot project, funded by a $100,000 grant from the U.S. Justice Department, two police officers equipped with video cameras are on duty Fridays and Saturdays from 8 p.m. to 1 a.m., when most domestic crimes occur. The officers, who are being trained on a volunteer basis, will be instructed to stop videotaping if the victim does not want to be recorded.

"We found we needed a better way to effectively ... preserve evidence," said **Reyne Rofuth**, author of the proposal and senior attorney in the city attorney's office. "By using video we can capture and freeze evidence for trial, regardless of whether the witness is present for trial." Some witnesses are afraid or unwilling to testify, she said. The program is believed to be the first of its kind in the nation.

The St. Paul Eastern District received more than 18,000 police calls for domestic disputes last year, including 2,396 assaults, according to **Cmdr. Don Winger**.

Medical Research

'U' Finds New Link Between Secondhand Smoke, Lung Cancer

University of Minnesota researchers have found new evidence linking secondhand smoke to lung cancer. At the national meeting of the American Chemical Society in September, they reported on a study in which the urine of passive smokers was found to contain a derivative of a carcinogen found only in tobacco smoke.

"This is the first time that a derivative of a tobacco-specific lung carcinogen has been found in the urine of nonsmokers exposed to environmental tobacco smoke under field conditions," said **Stephen Hecht, Ph.D.**, professor of laboratory medicine and pathology at the University of Minnesota.

The carcinogen, known as NNK, is the only known lung carcinogen found solely in tobacco smoke and is formed from nicotine. The researchers detected in the urine a substance called NNAL-Gluc, a derivative of NNK produced in the human body. Hecht said animal studies have shown that NNK is particularly efficient at inducing adenocarcinoma, the most common type of lung cancer found in nonsmokers exposed to environmental tobacco smoke.

The nine subjects of the study were nonsmoking hospital workers caring for live-in patients in the smoking area of a Canadian veterans hospital. Their urine samples were collected three times during one day at the end of a work week and sent to Hecht's laboratory. All nine test subjects had detectable NNAL-Gluc levels. No NNAL-Gluc could be found in control urine samples from laboratory personnel not known to have been exposed to cigarette smoke.

'U' Researchers Testing Drug to Curb Gambling Urges

In other University of Minnesota research, scientists are studying the effects of an anti-craving drug that has shown promise in reducing gambling urges. **Suck Won Kim, M.D.**, associate professor of psychiatry, is conducting the study after preliminary tests in 20 of his patients showed favorable results. The drug, which Kim declines to identify at this time, has been approved by the Food and Drug Administration for clinical use.

The study comes in response to the rapid growth of the gaming industry in Minnesota and nationwide. Approximately 40,000 adults in Minnesota suffer from severe gambling addiction.

All study participants will be given the drug for a six-week period. If the results are positive, a further study will follow. Anyone interested in participating should call 612/626-4034.

First Call Physicians, Inc.
A Locum Tenens Service
500 Eighth Ave. S.
Buffalo, MN 55313

Clinics/Hospital | **Physicians**

Locums Coverage
=
Revenue

- Patients falling through the gaps?
- Physician burnout or illness?
- Shortage of physicians?

- Earn more with less time.
- No administrative headaches.
- Malpractice premium paid.

Experience, Service, Honesty
Call (metro) 682-3852
(toll free) 888-682-3852

(You'll be glad you did!)

'U' Researchers Identify Special Class of Pain Nerves

In a step toward providing relief to burn victims and sufferers of chronic pain, researchers at the University of Minnesota and the Minneapolis Veterans Affairs Medical Center have identified a group of nerves that are instrumental in causing hypersensitive pain responses. Working with rats, the researchers showed that destroying a certain type of spinal nerve left the animals resistant to a treatment that usually causes hypersensitivity to heat and touch. The research was published in the October 10 issue of *Science*.

"We're beginning to uncover the chemistry of pain at a level we never understood before," said lead investigator **Patrick Mantyh, M.D.**, a researcher at the VA Medical Center and the University of Minnesota's School of Dentistry and psychiatry department. "It shows that there's an extremely small population of cells—no more than 1 percent of spinal nerves—

that plays a pivotal role in the generation of chronic pain."

Estrogen Alternative May Cause Fewer Side Effects

A new drug could provide all the benefits of estrogen replacement, such as stronger bones, but have fewer side effects, according to a Mayo Clinic study reported at the annual meeting of the American Society for Bone and Mineral Research. The anti-estrogen drug, raloxifene, helps increase bone mass and reduce blood cholesterol levels, said **Edward Lufkin, M.D.**, the study's lead author.

"But unlike estrogen, it avoids certain side effects, such as stimulation of the uterus and breasts; uterine bleeding was avoided and it did not cause any breast soreness," he said. The study did not determine whether the drug might contribute to breast cancer.

Vegetarian Teens at Higher Risk of Dangerous Eating Habits

Teenage vegetarians are more likely than other teens to vomit intentionally, use laxatives for weight control, binge eat, and follow other potentially dangerous eating habits, reported University of Minnesota epidemiologist **Dianne Neumark-Sztainer, Ph.D.**, in the August *Archives of Pediatrics and Adolescent Medicine*. She compared the eating and behavioral practices of 107 rural and small-town teenage vegetarians in Minnesota with those of 214 otherwise similar meat-eating adolescents.

The study found that 38 percent of vegetarians were frequent dieters (defined as dieting five or more times in the past year), compared with 21 percent of the nonvegetarians. Fifteen percent of the vegetarians engaged in self-induced vomiting, compared with 4 percent of the nonvegetarians. Eight percent of the vegetarians used laxatives to control their weight, compared with 1 percent of the nonvegetarians. Forty-four percent of the vegetarians said they engage in binge eating, compared with 32 percent of those who eat meat.

Violent Commercials Common During Baseball Playoffs

Children and adults who watched the 1996 major league baseball playoffs were exposed to overt violence in television commercials, according to Hennepin County Medical Center physician **Charles Anderson, M.D.**, whose study was published in the October 1 *Journal of the American Medical Association*. He studied the frequency of violent television commercials aired during the playoffs and World Series, traditionally thought to be family-oriented programming.

Anderson reports that during the 15 televised games reviewed, 104 (6.8 percent) of the 1,528 commercials contained violent content. In these 104 violent commercials, 69 contained at least one violent act, 90 contained at least one violent threat, and 27 contained evidence of at least one violent consequence.

Seventy (67.3 percent) of the violent commercials were promotions for television programs, seven were cable television program advertisements, and 20 were big-screen movie promotions.

"A parent can reasonably predict when violent programs will be aired," said Anderson. "A parent cannot reasonably predict that violent commercials may occur during a family-oriented program such as a baseball game."

He found that the violence was not subtle. The commercials included guns held to victims' heads, shootings, stabbings, forceful restraint, punching, bloody corpses, and burning bodies. He added that the dialogue was equally alarming.

AIDS Update

New Research Institute to Test Promising HIV Drug

The new Roseville-based Wayne Hughes Institute is teaming up with researchers in South Africa to test a promising new anti-HIV drug developed by the institute's director, **Fatih Uckun, M.D., Ph.D.**, who was formerly director of the University of Minnesota's Biotherapy Institute. Uckun discovered the drug, TXU-PAP, in the leaves of pokeweed plants he collected in 1990 while visiting Texas. Studies done in the laboratory and on animals show the drug is 1,000 times more potent than those currently used to treat AIDS patients, he said. The substance, which protects the pokeweed plant from virus attacks, instructs an infected plant cell to kill itself and the virus it contains. When injected into animals, the drug blocks an infected cell's ability to construct a new HIV virus.

Uckun said the institute's link to Africa is important for research because Africa is an "incubator" for diseases such as AIDS. Under a collaborative agreement, the drug will soon undergo clinical tests in South Africa under the direction of **Dr. Glenda Gray** at the University of Witwaterstrand in Johannesburg. So far, the drug has been tested on one patient from California and, as *Minnesota Medicine* goes to press, was being tested on a second.

The new institute is named after billionaire businessman **Wayne Hughes**, who pledged $200 million to form the research facility after a drug Uckun developed cured his son of leukemia. When conventional treatment failed, Hughes brought his son to the University of Minnesota to be treated with the drug, which drove the leukemia into remission. So far, Hughes has contributed more than $40 million to the center, which is dedicated to cancer and AIDS research.

CDC: AIDS Cases Declining, Infection among Women Rising

The number of new AIDS cases dropped 6 percent last year, the first decline since the epidemic began in the early 1980s, reported

the Centers for Disease Control and Prevention in September. The number of new cases in people over age 12 dropped from 60,620 in 1995 to 56,730 in 1996. The CDC said the trend and a recently reported decline in AIDS-related deaths are likely a result of powerful new drug treatments and prevention efforts that have prolonged symptom-free survival.

On a negative note, the number of HIV cases attributable to heterosexual transmission increased, jumping 11 percent among men and 7 percent among women.

The CDC also reported that the number of AIDS cases among women is rising more quickly than among men. From 1991 through 1995, the number of women diagnosed with AIDS increased by 63 percent compared with 12.8 percent for men. By the end of 1995, 67,400 women had been diagnosed with AIDS since the epidemic began. However, infected women still represented only 19 percent of all AIDS cases in 1995. Sex with infected men is the most likely cause of transmission; throughout the 1980s and early 1990s, the leading cause had been sharing an infected drug injection needle.

In another CDC study, researchers were surprised to find that an estimated two-thirds of all HIV-infected Americans already know they are HIV positive. The CDC estimates that 775,000 Americans carry HIV and that 500,000 of them have been tested and know their status. "This is encouraging because it suggests that the majority of persons with HIV have been tested," said **Patricia Sweeney, M.P.H.**, who directed the study. "We need to continue to work to ensure these people have access to recommended treatment." She presented her findings at an infectious disease conference sponsored by the American Society for Microbiology. MM





MMA Sponsors Club

The Minnesota Medical Association wishes to acknowledge the following and thank them for their generous contributions to the 1997 Annual Meeting.

SUSTAINING ($1,000 or more)

GlaxoWellcome

IKON Office Solutions

MMIC

PIC WISCONSIN

PATRONS ($500-$999)

ALLINA HEALTH SYSTEM

Allina Medical Group

CYCare

GLOBAL HOLIDAYS

HBO&Company

Johnson & Johnson

NORWEST To The Nth Degree™

OPPENHEIMER WOLFF & DONNELLY

Pharmacia & Upjohn

PROFILE GROUP

RELIASTAR

The St Paul Medical Services

3M Health Care

CONTRIBUTORS ($200-$499)

Allied Interstate, Inc.

ARAMARK

THE ARAZ GROUP

BUSHARD PRINTING

C.F. anderson COMPANY INC

CURTIS 1000

CONTRIBUTORS
($200-$499)

DORSEY & WHITNEY

Holiday Inn HOTEL & SUITES DOWNTOWN WATERFRONT

LOCKRIDGE GRINDAL NAUEN & HOLSTEIN P.L.L.P. Attorneys at Law

Madden's on Gull Lake

PIPER JAFFRAY

St. Croix Press

STUTZMAN-HELLING COMPANY Your Business and Tax Ally

Village Inn·Resort AT LUTSEN MOUNTAINS

HOSPICE

continued from page 14

hospice is still terribly underutilized, and referrals to hospice often come too late, when death is imminent and the patient and family have already suffered needlessly.

Hospice professionals provide palliative care for patients and help them and their families address the emotional and spiritual issues that are part of the dying experience.

Patients continue to be treated by their primary physicians, but the hospice program shifts the emphasis to home-based care by a specialized team of nurses, social workers, home health aides, clergy, and volunteers. This multidisciplinary team helps the individual and family capitalize on the personal growth opportunities that dying offers. Most important, physical symptoms are managed and patients are kept comfortable.

In this environment, family issues can be resolved and reconciliations made. The dying person can find peace and meaning while maintaining a sense of dignity. Families have a chance to say goodbye and let go, knowing that their loved one did not suffer and did not die alone. The hospice team also offers grief support and bereavement services to the family for one year following the patient's death.

In contrast, physician-assisted suicide offers only an end to suffering. It often ignores the multitude of unresolved issues, concerns, and regrets that contribute to the pain of dying. Very often there is no closure, no peace.

Of course, not all deaths in hospice are wonderful experiences. Sometimes, patients are referred with only days or even hours to live—after suffering through false hopes and fruitless therapies. Pain cannot always be completely managed, and not all family conflicts are neatly resolved. But hospice is based on a basic, unyielding respect for life that translates into the most caring, hands-on comfort that one could hope to receive. This basic tenet, rooted in respect for the individual, should serve as the cornerstone for all end-of-life care.

The Future of the Debate

"I don't want to achieve immortality through my work. ... I want to achieve it through not dying."

–Woody Allen

Why has hospice been so quiet? Medical advances in this century and the mass marketing of youth and fitness ideals have created a generation of Americans who deny life's inevitable end. The debate on physician-assisted suicide is emblematic of a society that has trouble dealing with the realities of death. It's time for hospice to step forward as an answer that we can all support.

The questions of physician-assisted suicide and end-of-life care will likely remain on the American agenda. In the next year, 21 state legislatures will consider bills dealing with pain treatment for dying patients. Kevorkian will surely continue his personal crusade to end suffering. Meanwhile, a generation of babyboomers is caring for aging parents while facing their own mortality.

The medical community has a tremendous opportunity to drive these discussions by supporting a program that is medically and ethically sound—a program that provides physical, emotional, and spiritual relief. Through hospice, we can better understand dying as a part of life, as something to be cherished rather than avoided. Hospice offers hope for a more open acceptance of death—and greater respect for life. MM

Matt Malloy is a former hospice provider relations manager and a former board member of the Minnesota Hospice Organization.

A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

NOVEMBER 1997

Nov. 10-12 **Clinical Reviews 1997** Mayo Foundation; Mayo Civic Center, Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 13-15 **Mayo Clinic Ob/Gyn Clinical Reviews** Mayo Foundation; Rochester, MN. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Nov. 14 **E.T. Bell Pathology Symposium** University of Minnesota; Radisson Hotel–Metrodome, Minneapolis, MN. CONTACT: Office of Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600 or 800/776-8636.

Nov. 14-15 **Laboratory Diagnosis of Fungal Infections** Mayo Medical Laboratories; The Founders Inn and Conference Center, Virginia Beach, VA. CONTACT: Julie McAdams, 200 First Street SW, Rochester, MN 55905; 507/284-8599.

Nov. 21-22 **Osteoporosis Conference** Hennepin County Medical Center; Doubletree Grand Hotel, Bloomington, MN. CONTACT: Hennepin County Medical Center Continuing Medical Education, 701 Park Avenue, Mail Code 869A, Minneapolis, MN 55415; 612/347-2075 or 888/263-4262.

DECEMBER 1997

Dec. 4-5 **Current Issues in Phlebotomy and Point-of-Care Testing** Mayo Medical Laboratories; The Peabody Hotel, Memphis, TN. CONTACT: Julie McAdams, 200 First Street SW, Rochester, MN 55905; 507/284-8599.

JANUARY 1998

Jan. 12-16 **Bone and Soft Tissue Tumors: A Multidisciplinary Approach** Mayo Foundation; Ihilani Resort, Oahu, HI. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jan. 19-23 **Continuing Challenges in Hematology, Oncology, and Hematopathology** Mayo Medical Laboratories; The Silvertree Hotel, Snowmass, CO. CONTACT: Julie McAdams, 200 First Street SW, Rochester, MN 55905; 507/284-8599.

FEBRUARY 1998

Feb. 26-28 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 27-Mar. 1 **Current Concepts of Erectile Dysfunction: Diagnosis and Treatment** Mayo Foundation; Caribe Royale Resort Suites, Lake Buena Vista, FL. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MARCH 1998

Mar. 8-11 **Neurology in Clinical Practice** Mayo Foundation; Silvertree Hotel and Wildwood Lodge, Snowmass Village, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 9-13 **Selected Topics in Internal Medicine** Mayo Foundation; Maui Prince Resort, Maui, HI. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., November 15 for January ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

Olmsted Medical Center is seeking BC/BE physicians in family medicine. Great opportunity for well-trained physicians to join a 75-physician multispecialty group in a dynamic, progressive practice. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes 10 branch office locations in southeastern Minnesota. Excellent salary/benefits including malpractice, flexible benefits, 401k/403b and profit sharing, and relocation assistance. Send CV to Olmsted Medical Center, Attn: Lois Till-Tarara, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (*5/96-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Part-time Neurologist wanted for multidisciplinary office. No call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Urgent Care Physicians: We are a growing urgent care practice looking for BC/BE physicians to work full or part time to staff our four clinics. We currently have three locations in the metro area and one location in Mankato and are planning on expanding in 1997. Please contact Cara Auge at 612/593-9818 or 800/511-2820 for more information on joining our growing practice, or send inquiries to 9800 Shelard Parkway, #210, Plymouth, MN 55441. (4/97-R)

Office Space for Rent: Medical/dental only, Burnsville, 35W/35E interchange. Modern, 2,000 square feet. Garage parking. Call Dick, 612/435-4144. (8/97-R)

Ob/Gyn BC/BE to join progressive 33-physician multispecialty group practice. Rural setting with metropolitan practice style, 24 miles from Minneapolis. Group has excellent reputation and large geographic referral area. Recently expanded facility is adjacent to newly remodeled 110-bed hospital. Comprehensive benefits package with excellent remuneration. Interested physicians should contact Joseph E. Van Kirk, M.D., Lakeview Clinic, Ltd., 424 State Highway 5 West, Waconia, MN 55387; 612/442-4461. AOA/EOE. *3-11/97

Mankato, Minnesota: Full-time psychiatrist. Excellent opportunity for BC/BE psychiatrist to join our multidisciplinary team. Competitive salary and benefit package. Mankato is a high-quality town 70 miles south of Minneapolis. Excellent schools and recreational activities. For more information, contact Ed Sathoff, M.D., or Patricia Blumenreich, M.D., at 507/387-3195, or send/fax CV to Psychiatric Clinic, 410 Jackson Street, Suite 200, Mankato, MN 56001; Fax: 507/625-2224. 3-11/97

Family Practice—rural but near: Independently owned primary care group located 45 minutes from Minneapolis seeks family practice physician. Growing community offers professional options for significant other, walking and biking trails, good school choices, strong economic base, and safe environment. Practice offers four-day clinic week, 1:6 call, supportive colleagues, new facilities, and dedicated staff. Call Verne Meyer, 800/967-2711, or fax CV to 320/587-7252. E-mail: delacore@hutchtel.net. 3-11/97

CENTRACare CLINIC

CentraCare Clinic, a multispecialty group of 87 physicians based in St. Cloud, currently has the following openings within our multisite system:

Noninterventional Cardiology	Neurology
Internal Medicine (Little Falls)	Family Practice (Melrose)
Gastroenterology	Infectious Disease

CentraCare Clinic is a progressive, rapidly growing group offering an outstanding lifestyle, compensation and benefits. Our clinics are conveniently located between the Twin Cities and prime Minnesota lake areas.

Contact: John Schnettler
Physician Recruiter
St. Cloud Hospital
1406 Sixth Avenue North
St. Cloud, MN 56303
800-835-6652

Family Practice—Chetek: Luther Midelfort–Mayo Health System, a thriving 160-physician multispecialty clinic and hospital in Eau Claire, Wisconsin, is seeking a BC/BE family practitioner for our Chetek, Wisconsin, office. A desire to practice ob is essential. General call of 1:10 and ob call of 1:7 is expected. Physicians do not have first call in the emergency department. Will share a newly remodeled office with one other family practitioner. Chetek, located 40 miles north of Eau Claire, is in the heart of resort country. Located on a chain of six connecting lakes, Chetek offers four-season recreation for the outdoor enthusiast. For further information, contact Christie Blink, Physician Recruitment Coordinator, at 800/573-2580, or fax 715/838-6688. 3-11/97

Psychiatry—rural but near: Seeking the fourth staff psychiatrist for an expanding community psychiatry center. Practice offers highly qualified colleaues, a multidisciplined approach, beautiful facilities, competitive salary, and benefit programs. This growing community, located within one hour of Minneapolis, offers professional options for significant other, walking and biking trails, good school choices, strong economic base, and a safe environment. Contact Verne Meyer, 800/967-2711, fax 320/587-7252, or E-mail: delacore@hutchtel.net. *3-12/97

A place to practice, a place to live

Mpls St Paul magazine ranks Owatonna one of Minnesota's eight great small towns. We enjoy:
- Proximity to the Twin Cities
- Excellent schools
- Pleasant neighborhoods
- Recreational opportunities

A growing group practice of 28 physicians, we want to expand our physician team in:
- Family practice
- Internal medicine
- Obstetrics and gynecology

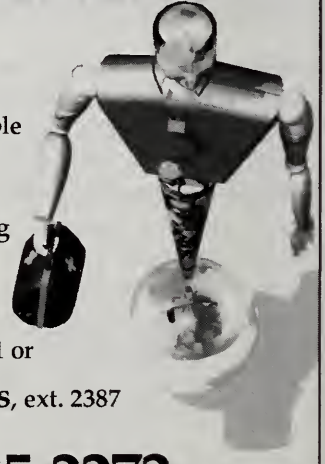
For more information contact David Berg, Owatonna Clinic administrator, at 507-455-4441.

Owatonna Clinic
Mayo Health System

Staff Care, Inc.
"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS

- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging



Ask for :
John Moberly, ext. 2381 or
Melanie McReynolds, ext. 2387

(800) 685-2272
http://www.locumsnet.com

Staff Care is proud to sponsor *the Country Doctor of the Year Award*

Unable to place J-1 or H-1 physicians

Emergency Medicine: Olmsted Medical Center is a 75-physician integrated health care system located in Rochester, Minnesota. We are currently searching for a BC/BE primary care physician with emergency medicine experience. ACLS, ATLS, and PALS certifications are required. Our low acuity emergency department has an annual volume of 16,000 patients and advanced technology to provide the highest quality care. Excellent salary and benefits. Malpractice insurance coverage provided. Rochester has been listed as one of the most livable cities in the United States for four years in the *Money* magazine survey. Send CV or call Lois Till-Tarara, Olmsted Medical Center, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. 4-2/98

Occupational Medicine—Minneapolis: BC/BE occupational medicine physician needed to join the 13-member occupational medicine department of a 422-physician multispecialty clinic in desirable Twin Cities area. We serve over 2,000 different client companies in the metro area and region. Opportunity for teaching and clinical research is available. Comprehensive, generous benefit program. For additional information, contact Patrick Moylan at 612/993-5986 or send CV and letter of inquiry to Mr. Moylan, Professional Practice Resources, Park Nicollet Clinic, HealthSystem Minnesota, 3800 Park Nicollet Boulevard, St. Louis Park, MN 55416, or fax 612/993-2819. 2-11/97

Urgent Care Physicians

Urgent care openings at five Procare sites throughout the Twin Cities. BE/BC Family Practitioners and Internists, comfortable with pediatrics, to work evenings, weekend, and holidays. Permanent part-time (32-40 hours every two weeks) with benefits. Moonlighting needed and will consider residents.

MERCY & UNITY HOSPITALS
ALLINA HEALTH SYSTEM

For more Information:
Debbie Modder
Allina Health System
5601 Smetana Drive Route 80775
612-992-3094 / 800-284-4921
Fax: 612-992-2927

Neurologist, Oncologist, Urgent Care, ENT, Dermatologist

There are immediate openings at Brainerd Medical Center for the following specialties: Neurology, Oncology, Urgent Care, Ear, Nose and Throat, and Dermatology.

Brainerd Medical Center, P.A.
- 36-physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota
- Surrounded by the premier lakes of Minnesota
- Located in central Minnesota less than 2 ½ hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:
- Curt Nielson
  (218) 828-7105
  or (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

A Healthier Future

Southern Minnesota

Seeking quality primary care trained or emergency medicine physician(s) to practice in ***Blue Earth, Fairmont, Owatonna and Worthington.***

- Stellar Emergency Medicine Practice
- Full-time, regular part-time and moonlighting opportunities
- No restrictive covenants
- Fully accredited CME programs
- St. Paul malpractice insurance
- Competitive bonus, benefit and compensation packages.

ACUTE CARE, INC.

Respond to Melissa Milliken, CMSC, CMSR, Director of Development, 515-964-2772, 800-729-7813 or send CV to P.O. Box 515, Ankeny, Iowa 50021.



ALEXANDRIA CLINIC, P.A.

The Alexandria Clinic, P.A., is a 32-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- ENT
- INTERNAL MEDICINE

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

FAMILY PRACTICE MEDICAL CENTER
OF WILLMAR, P.A.



Family Practice Opportunity: Seven-family physician group seeks additional full-time family physician. Family Practice Medical Center of Willmar, Minnesota, P.A., is a physician-owned clinic located in the regional health care center for west-central Minnesota. Broad secondary specialist services provided in community, 24-hour ER physician coverage, and after-hour nurse triage service. Teaching opportunities as clinical faculty for University of Minnesota. Guaranteed salary first year, with a full range of benefits and the opportunity for ownership. Outstanding quality of life including four-season recreational opportunities, strong community economy, excellent educational system, and a regional retail center. Inquiries to Gary McDowell, Administrator, at 320-235-7232, or fax 320-231-8602.

Minnesota: BC/BE general orthopedist or medical orthopedist needed to complement a well-established solo orthopedic practice. Competitive salary guarantee and benefits. Excellent schools, recreation, and outdoor activities. Subspecialty training welcome. Please fax resume to Lori at 507/238-1997. 3-11/97

Dentistry Faculty: The University of Minnesota School of Dentistry invites applicants through June 30, 1998 for part-time, nonregular faculty for consultative, diagnostic, and treatment planning services in specialty clinics. M.D. required with training and experience in otolaryngology or reconstructive surgery cleft palate patient care. Faculty rank dependent upon experience and training. Send resume (indicating specialty or areas of clinical expertise) to Dean Michael Till, University of Minnesota School of Dentistry, 15-209 Moos Tower, 515 Delaware Street SE, Minneapolis, MN 55455. The University of Minnesota is an equal opportunity educator and employer. 1-11/97

NOVEMBER 1997 INDEX TO ADVERTISERS

Acute Care Inc. 63
Affiliated Community Medical Centers 13
Air Force Health Professionals–Ft. Snelling 5
Alexandria Clinic, P.A. 64
Allina Health System 31, 54, 63
Aspen Medical Group 32
Brainerd Medical Center 63
CentraCare Clinic 62
Central Minnesota Group Health Plan 31
Fairview Clinic Services 53
Family Practice Medical Center 64
First Call Physicians, Inc. 55
Franciscan Skemp Healthcare 57
Gillette Children's Specialty Healthcare 12
Global Holidays 48
HealthEast–Bethesda 3
HealthSystem Minnesota 44
Medical Protective Company ..... Cover 2
Midwest Medical Insurance Co. 9
MMBR ..... Covers 3 and 4, 41, 49
Monroe Clinic 48
Multicare Associates of the Twin Cities 54
Owatonna Clinic 62
Regions Hospital 8
St. Mary's/Duluth Clinic Health System 13
Staff Care, Inc. 62
Star Tribune 13
University of Minnesota 44
Whitesell Medical Locums, Ltd. 51

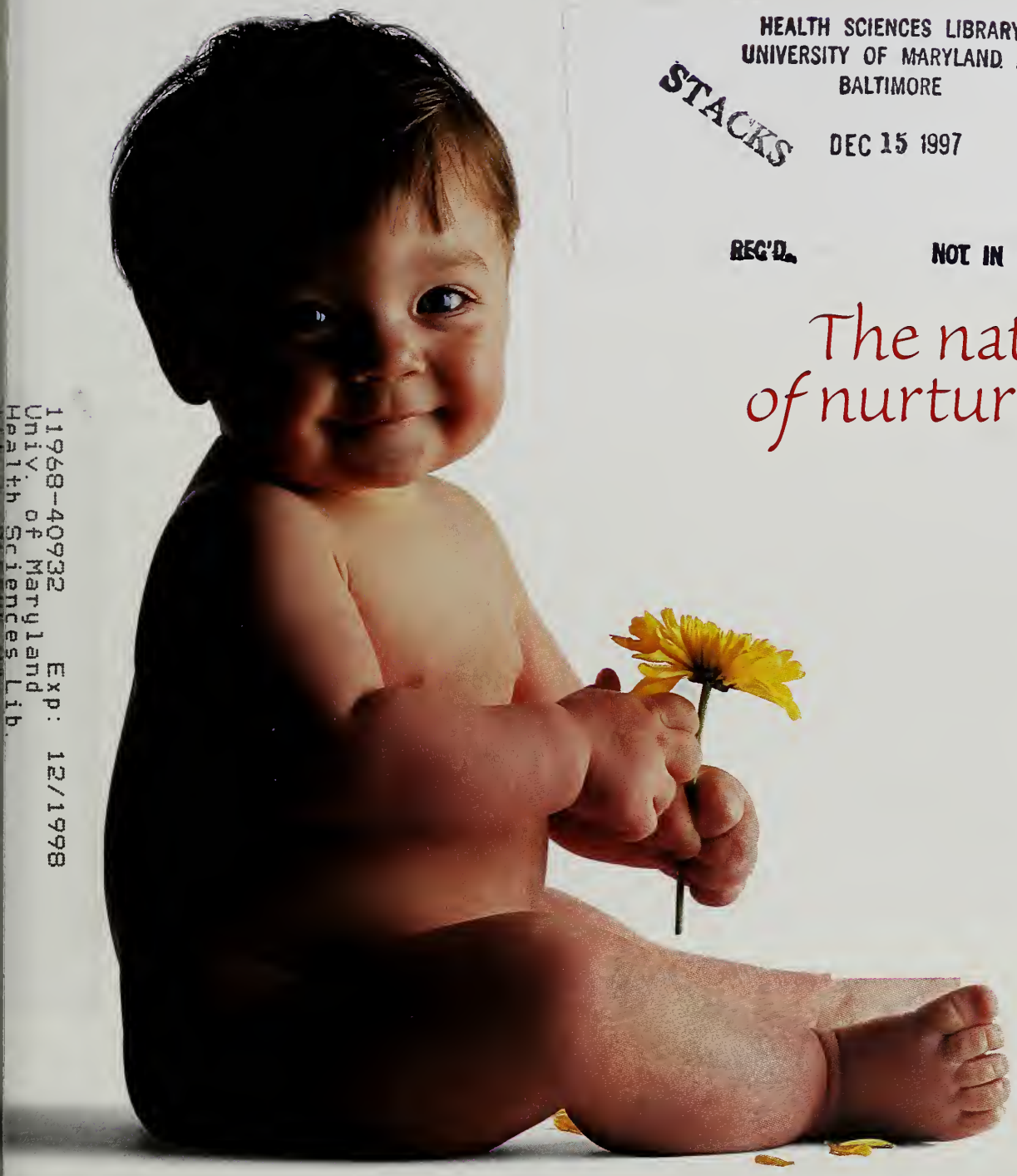
MinnesotaMedicine

A JOURNAL OF CLINICAL AND HEALTH AFFAIRS

HEALTH SCIENCES LIBRARY
UNIVERSITY OF MARYLAND AT
BALTIMORE

STACKS DEC 15 1997

REC'D. NOT IN CIRC.



The nature of nurturing

11968-40932 Exp: 12/1998
Univ. of Maryland
Health Sciences Lib.

BRINGING up BABY

DECEMBER 1997

Partners In Your Future



"When I began my practice, there was a malpractice crisis in the United States. MMIC was there and they were very helpful. They have always been very supportive."

Judith Shank, MD
Metropolitan Dermatology
Plymouth, MN

In today's changing medical environment, physicians need to view their professional liability insurer as an important partner in their future. And what better partner can a physician have than a physician-owned and controlled liability insurer such as Midwest Medical Insurance Company. A company that understands a physician's desire to practice the art of medicine.

As your partner, MMIC is here to assist you in your new working relationships and to develop products and programs which improve patient care and lower liability exposures.

MMIC is here for the long term. We bring to the partnership a financial strength of over $251 million in assets and a total equity of over $104 million. Our rating from A.M. Best is A (EXCELLENT).

For a competitive quotation and other information on services offered by MMIC, please call us at 1-800-328-5532.

MMIC

MIDWEST MEDICAL INSURANCE COMPANY
6600 France Avenue S. Minneapolis, MN 55435-1891

Minnesota Medicine

Published monthly by the Minnesota Medical Association



COVER

Cover photograph of Jordan Noltner by his dad, John Noltner.

DEPARTMENTS

2 ..... Editor's Note

6 ..... Letters to the Editor

56 .... News Clips

61 .... CME in Minnesota

63 .... Classified Ads

64 .... Index to Advertisers

65 .... 1997 Annual Index

FACE TO FACE

8 **Seeing the Child Behind the Diagnosis** ..... Jeremiah C. Whitten
Rachel Trockman, M.D., considers the "whole patient" when treating kids with severe school and behavior problems.

PERSPECTIVES

10 **Learning the Language of Fatherhood** ..... J.W. Bromfield
A first-time father wraps his son in the comfort of words.

COVER STORIES

12 **Bringing Up Baby: The Nature of Nurturing** ..... Douglas Clement
U of M researchers from several disciplines are collaborating to study the complex array of factors that shape the developing brain.

20 **Physicians Prescribe Parent Education** ..... Susan Maas
All parents can benefit from the many programs available to help them with one of life's most challenging jobs.

COMMENTARY

24 **Close Ties to Parents, School Improve Adolescents' Lives** ..... Michael D. Resnick, Ph.D.

SPECIAL REPORTS

27 **Building Assets: A Positive Approach to Adolescent Health** ..... Nancy Leffert, Ph.D.

31 **Achieving Universal Health Care Coverage for Children: The Minnesota Experience** ..... Charles N. Oberg, M.D., M.P.H., and Deborah Chase, M.P.A.

CLINICAL & HEALTH AFFAIRS

45 **The Incidence of Child Suicide in Minnesota** ..... Jon Roesler, M.S.

PUBLIC HEALTH REPORTS

48 **Routine Screening During Pregnancy: The New Minnesota Pregnancy Risk Assessment Form** ..... Pamela Weiss, Ph.D., R.N., and Peter M. Mark, M.D.

50 **Creating a Statewide Immunization Registry: A Tool for Physicians and Public Health** ..... Martin LaVenture, M.P.H., Myrlah Olson, B.S.N., M.P.H., Bill Brand, M.P.H., and Byron Crouse, M.D.

MEDICINE LAW & POLICY

53 **Minor Consent to Treatment** ..... Kimberly Halva, J.D., M.P.H.
When can physicians treat minors without a parent's consent?

33 The Monitor

Highlights ..... *Physicians' guide to support services for parents of babies and toddlers • MMA launches antismoking efforts*

Being There

Parents do matter. That's the take-home theme from this month's *Minnesota Medicine*. From their first steps to the day they leave home, our kids navigate a baffling, tumultuous sea. Their stability and direction is challenged at every turn. Although school, community, and peers are important, parents are the beacons ensuring that kids are not lost at sea.



Constant connection is the *sine qua non* of parenting. The bond starts with the first cry. I have an indelible memory of holding my first-born in the delivery room and realizing that I truly loved her on first sight. As noted in our cover story by Doug Clement, the bonds parents establish in a child's earliest hours may fashion the emotions, behavior, and even biochemistry of the future adolescent or adult.

"Most of us learn parenting by example. If we're lucky, we've received valuable lessons to pass on."

Our connection with our kids undergoes many metamorphoses, but through all of these changes we retain three jobs: teacher, guide, and nurturer. At times the roles may seem dormant, but we're always playing them.

From first words to driving lessons, we teach our kids. Overtly, we teach them the lifesaving skills (crossing the road safely, swimming, driving) and the life-enhancing skills (throwing a ball, reading, riding a bike). Covertly, we teach them what is good and what is important.

From the first "no" to helping them choose a college, we guide our kids. They may not always know it, like it, or ask for it, but guidance is offered and, believe it or not, it's always heard. Kids hear their parents talking to them, even when the "kids" are grandparents.

From the first "I love you" to the "Godspeed" at marriage, we nurture our kids. Nurture is a hazy mix of love and reason that tells kids, "You are safe here. You are a good person." Nurture is the fertilizer that promotes healthy growth.

Robert Coles in his book "Moral Intelligence"—which he says is "about the way character develops in the young ... about what makes a good person"—calls for parents to be "moral companions" for children. This means being a daily role model and being there to explain the whys of the world—"the day in, day out embrace of values and ideals that gets called life—there children get a visible, an audible, a palpable 'character in action' lesson."

These jobs take time, chronological and mental. Being there for your children means more than a warm, adult body. I recently heard historian Doris Kearns Goodwin speak about her Brooklyn childhood. Unlike many memoirists, she spoke glowingly about her father, who shared her passion for the hapless Brooklyn Dodgers. Her father would arrive home after a long day as a bank auditor and listen for two hours as 9-year-old Doris gave him a play-by-play description of the Dodgers' game. Now that's being there!

It's not easy. And, ironically, few parents get formal instruction in the most important job of their lives. Most of us learn parenting by example. If we're lucky, we've received valuable lessons to pass on. A few years ago, in a fit of Christmas spirit, I put my hopes for my kids on paper and gave it to them on Christmas morning. Amidst the toys and the wrapping, it seemed to get lost, and I figured it had fallen on too-young ears. This is what it said:

"This is my wish for my children: To develop an unquenchable curiosity about the world and to never lose their wonder at it; to build wisdom that grows until their last breath; to feel joy, to see majesty, and to sense the sacred in each day; to find one love for one life; to know God's grace from sunrise to sunset."

I have since found the paper tucked away in a special place in each kid's room.

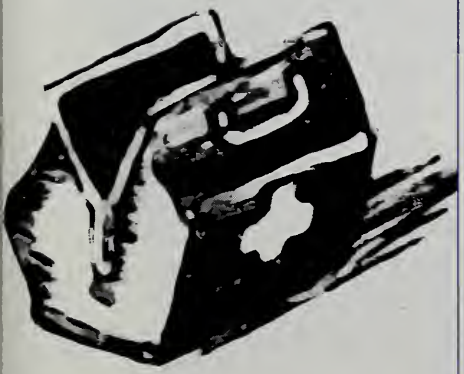
They're always listening.

–Charles R. Meyer, M.D., Editor-in-Chief

THE *HARDEST PART* OF FINDING THE RIGHT JOB SHOULDN'T BE FINDING THE RIGHT *JOB postings*







PRACTICE RESOURCES

MINNESOTA'S ULTIMATE MEDICAL PLACEMENT RESOURCE

The ideal physician candidates for your clinic's open positions for physicians are out there, right now, trying to find your job postings. Can they find them?

Just 5 minutes of your time can put your job postings in the hands of over 3,000 physicians each month. It is easy and cost effective with Practice Resources®, a new, Internet and telephone-based regional database of practice opportunities. Just a few minutes of your time spent completing a short form is all that is needed to create an audio script and Internet posting that will generate interest and qualified responses to your posting.

Placement opportunities are accessible nationally by physicians through a toll-free call or the Internet web site. Physicians can quickly search through hundreds of postings by specialty or location. More than 3,000 physicians nationwide use the service each month.

Physicians can respond confidentially by dictating a mini-CV via voice mail or completing an application form online. Candidate responses are faxed to you the next business day.

Practice Resources complements your recruitment strategies and is priced to fit within your budget. Special rates are available for placement in both Practice Resources and *Minnesota Medicine*, the monthly journal of the Minnesota Medical Association. To learn more about the service or to place a position, call David Franz at (888) 884-8241 or complete the attached reply card.

MMBR

Minnesota Medical Business Resources
Owned By
MMA & HMS

Powered By ART

Practice Resources is a joint venture of Minnesota Medical Business Resources (MMBR) and Applied Recruitment Technologies (ART). MMBR is a wholly owned subsidiary of the Minnesota Medical Association and the Hennepin Medical Society.

Minnesota Medicine

Published monthly by the Minnesota Medical Association

Owner and Publisher
Minnesota Medical Association

Editor-in-Chief
Charles R. Meyer, M.D.

Managing Editor
Meredith McNab

Associate Editors
Lee J. Engfer
Susan Rodsjo

Assistant Editor
Juliet Ramotar

Public Health Reports Editor
Barbara P. Yawn, M.D., M.Sc.

Graphic Designers
Lee J. Engfer
Mike May
Susan Rodsjo

Send manuscripts, subscriptions, and other material for consideration to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875. E-mail: mm@mnmed.org
The editors reserve the right to reject editorial, scientific, or advertising material submitted for publication in *Minnesota Medicine.* The views expressed in this journal do not necessarily represent those of the Minnesota Medical Association, its editors, or any of its constituents. Annual subscription–$40. Single copies–$3.50. Canadian–$70. Foreign–$70.

To Advertise: Contact Sherry Makela, *Minnesota Medicine*, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/623-2880 or 800/DIAL MMA (342-5662).

The Monitor

Editor
Lorrie Holmgren

Advisory Committee

Editor-in-Chief
Charles R. Meyer, M.D.

Advisory Committee
Charles R. Meyer, M.D.
Quentin N. Anderson, M.D.
Edmund C. Burke, M.D.
Richard C. Lussky, M.D.
Paul S. Sanders, M.D.
Leighton G. Siegel, M.D.
Leif I. Solberg, M.D.
Barbara P. Yawn, M.D.
Therese Zink, M.D.
Meredith McNab, staff

Editors Emeritus
Edmund C. Burke, M.D. 1991-1993
Richard L. Reece, M.D. 1975-1990
Reuben Berman, M.D. 1971-1974
Carl O. Rice, M.D. 1961-1970

Copyright & Post Office Entry

Minnesota Medicine (ISSN 0026-556X) is published on the fifth of each month by the Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761, copyright 1997. Permission to reproduce editorial material in this magazine must be obtained from *Minnesota Medicine.* Periodicals postage paid at Minneapolis, Minnesota, and at additional mailing offices. POSTMASTER, send address changes to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761. (USPS 3519000.)

MINNESOTA MEDICAL ASSOCIATION

1997-98 Officers

President
Kent S. Wilson, M.D.

President-Elect
Judith F. Shank, M.D.

Chair, Board of Trustees
Paul C. Matson, M.D.

Vice President
Anthony C. Jaspers, M.D.

Secretary
Robert G. Milligan, M.D.

Treasurer
Noel R. Peterson, M.D.

Speaker of the House
Blanton Bessinger, M.D.

Vice Speaker of the House
Gary D. Hanovich, M.D.

Past President
Raymond G. Christensen, M.D.

Chief Executive Officer
Paul S. Sanders, M.D.

Alliance

President
Kendra Flanagan

President-Elect
Dianne Fenyk

Board of Trustees

N.W. District
Jerry P. Rogers, M.D.

N.E. District
James L. Anderson, M.D.
Charles R. Helleloid, M.D.

N. Central District
James J. Dehen Jr., M.D.
Keith D. Larson, M.D.

West Metro
Karen K. Dickson, M.D.
John W. Larsen, M.D.
Robert K. Meiches, M.D.
Henry T. Smith, M.D.
Benjamin H. Whitten, M.D.

East Metro
John R. Balfanz, M.D.
Joseph L. Rigatuso, M.D.

S.W. District
Thomas G. Birkey, M.D.
Paul C. Matson, M.D.

S.E. District
Peter Amadio, M.D.
G. Richard Geier Jr., M.D.
Stephen G. Harner, M.D.

Resident Member
Lynn Bergquist, M.D.

Medical Student
Edd Lawson Evans

AMA

AMA Trustees
William E. Jacott, M.D.

AMA Delegates
Robert D. Christensen, M.D.
A. Stuart Hanson, M.D., *Chair*
Frank J. Indihar, M.D.
Carolyn J. McKay, M.D.
Audrey M. Nelson, M.D.
Ben P. Owens, M.D.
Andrew J. K. Smith, M.D.

AMA Alternates
Raymond G. Christensen, M.D.
Kenneth W. Crabb, M.D.
Lyle Munneke, M.D.
Thomas L. Peyla, M.D.
Sally Trippel, M.D.
John M. Van Etta, M.D.

MMA Senior Staff

Director of Legal Affairs
Patricia L. Franklin, J.D.

Chief Financial Officer
George C. Lohmer Jr.

Director of Legislation and Public Policy
David Renner

MMA Address

Minnesota Medical Association, 3433 Broadway Street NE, Suite 300, Minneapolis, MN 55413-1761; 612/378-1875 or 800/DIAL MMA (342-5662)

Fax: 612/378-3875

E-mail: mma@mnmed.org

Web site: www.mnmed.org

Advance career as physician?

Yes

No

Finding the ideal practice opportunity as a physician just got a whole lot easier—introducing Practice Resources, Minnesota's Ultimate Medical Placement Resource. Practice Resources is a regional database of physician career opportunities that is easy to use, fast and free. Practice Resources is available through the Internet and through a toll-free telephone call.

- Search the listings by specialty or location.
- Get detailed descriptions about the opportunity.
- To post an opportunity profile, call our business office at 888-884-8241.
- Apply directly by dictating a confidential mini-CV or e-mailing an application.

www.mnmed.org

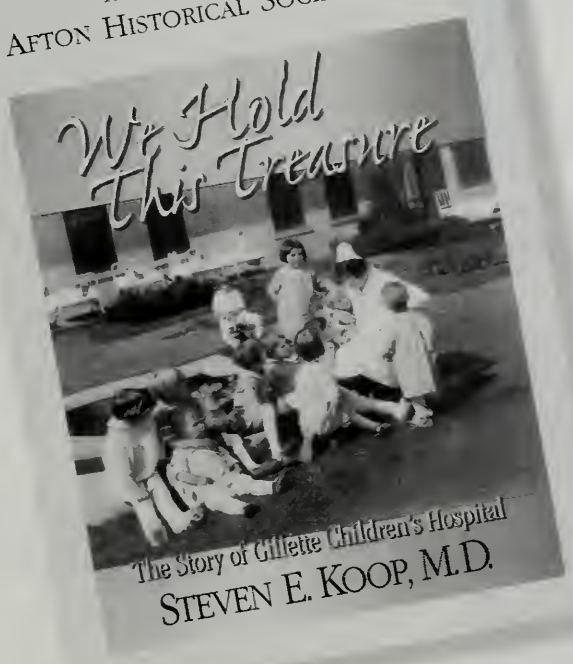
888-884-8242

Practice Resources is a joint venture of Minnesota Medical Business Resources (MMBR) and Applied Recruitment Technologies (ART). MMBR is a wholly owned subsidiary of the Minnesota Medical Association and the Hennepin Medical Society. ART is an independent communications company.

PRACTICE RESOURCES

MINNESOTA'S ULTIMATE MEDICAL PLACEMENT RESOURCE

A new book from the Afton Historical Society Press!



The Story of Gillette Children's Hospital

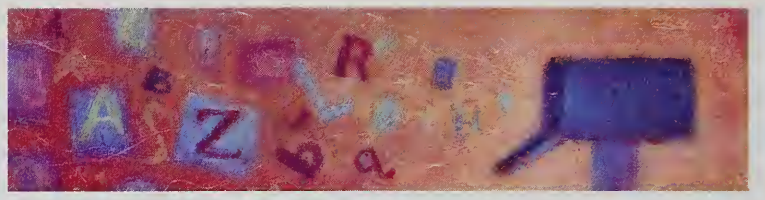
Spanning the years 1895 to the present, this book tells about the lives of the medical staff and the patients who formed Gillette Children's Specialty Healthcare. This book is not a study of an institution's history but a look at the many individuals the author discovered. We Hold This Treasure is an intriguing journey of human discoveries by a dedicated doctor and staff who spent years researching the many stories uncovered within.

9" X 11", 180pp., extensive archival photography
Casebound in linen, $49.

To order your copy, call **(612) 229-3837**
Fax requests to **(612) 229-3930**
E-mail requests to **KOOPX001@maroon.tc.umn.edu**

Gillette Children's
Specialty Healthcare

Gillette Children's Specialty Healthcare
200 East University Ave.
St. Paul, MN 55101



A Heartfelt Thanks

Thank you for your July article ("A Heartening Exchange") on Children's HeartLink's international missions, which help children with heart disease and assist cardiovascular programs in developing countries.

After seeing the article, the St. Paul Midway Rotary Club informed us of their storage site for donated medical supplies. From their facility we obtained an overwhelming array of items ideal for the cardiovascular surgery programs we assist in East Africa and Latin America. Our international friends will be thrilled to receive the surgical highlights, suction machines, cauteries, and countless other items the club has so generously offered.

With the stringent controls on expiration and reuse of medical supplies in the United States, so much goes unused or unrecycled—a terrific waste. Many needy countries can still safely use these supplies. Children's HeartLink receives donations from medical volunteers, hospitals, and medical supply companies that keep us in mind when supplies are available.

For more information on the Midway Rotary Club's distribution program, contact Richard Sundberg, 612/699-5075, or Charles MacDonald, M.D., 612/291-8773. For more information on Children's HeartLink and how you can volunteer your services, donate equipment, or sort supplies, contact Katie Regnier at 612/928-4860, ext. 16.

Children's HeartLink was founded in Minnesota 28 years ago and has continued its mission, thanks to the state's generous medical professionals.

Katie Regnier
Children's HeartLink
Minneapolis, Minnesota

Public Health/Flood Issue Timely and Useful

I found the contents of the August *Minnesota Medicine* timely since I recently assumed the role of health officer for the city of Fargo and Cass County. My career is currently split between research and public health, so I was very interested in the profile of Dr. Neal Holtan and his work as both an internal medicine physician and medical director of the St. Paul-Ramsey County Department of Public Health.

I also am on the city council of a small community (70 residents) just north of Fargo. Our town, located on the river, spent last spring dealing with many of the flooding problems described in *Minnesota Medicine*. Fortunately, we experienced no major medical problems, even though the potential for injury was great.

Thanks again.

Mary Alice Gillispie, M.D.
Director, Fargo Cass Public Health
Fargo, North Dakota



Thanks for Addressing Domestic Abuse

As director of a battered women's program, I want to thank you for focusing on domestic violence in the October *Minnesota Medicine*. It is critical that we enhance physicians' knowledge and response to this epidemic.

Again, thank you for your support on this issue.

Maxine Barnett
Executive Director
Central Minnesota Task Force on Battered Women
St. Cloud, Minnesota

Just Part of the Domestic Abuse Picture

I was disappointed to find that article after article in your October issue on domestic abuse related only stories of male abuse against women and children. This journal was not about domestic violence; it was only about abusive men and how to fix them. Certainly this is a serious problem in our society with a multifactorial etiology; however, by avoiding the equally serious issues of women abusing women and men abusing men in same-sex relationships, and women abusing men in heterosexual relationships, you do a disservice to your readers and perpetuate stereotypes popular with the feminists and the media in this country.

Mark T. Sprangers, M.D.
Medical Director
Occupational Medicine Department
Interstate Medical Center
Red Wing, Minnesota

HealthEast Capitol Medical Laboratory

The Solution to Your Reference Laboratory Needs

Locally owned and operated

Accurate cost-effective testing
24 hours a day, 7 days a week

Technical consultant services

Continuing education seminars

Providing services to:
• physician office laboratories •
• long-term care facilities •
• group home •
• home health care agencies •

For more information, contact
CML Marketing at
(612) 232-3246

HealthEast Capitol Medical Laboratory
69 West Exchange Street
St. Paul, MN 55102-1004
Customer Service: (612) 232-3500

Seeing the CHILD Behind the Diagnosis

Rachel Trockman, M.D., considers the "whole patient"—mind, body, and circumstances—to treat youngsters with the most puzzling, most severe, school and behavior problems.

Jeremiah Christopher Whitten

Remember from elementary school the kid who spent as much time in the principal's office as in the classroom—the kid who was always in trouble?

This is the child Dr. Rachel Trockman seeks out. Take, for example, the third-grader about to be kicked out of school for inappropriate behavior—swearing and grabbing little girls in a sexual manner. His wild ways were disturbing the class and preventing him from learning to read and write.

Luckily for the young boy, his school sent him to Trockman, founder and director of the Child Behavior and Learning Clinic at Hennepin County Medical Center, who discovered the boy was experiencing a type of continuous seizure. Once the seizure was controlled with anticonvulsive medication, his behavior became normal and he caught up academically within a year.

Trockman and her colleagues diagnose and treat children (90 percent of whom are boys) with conditions that include attention deficit disorder, specific learning disabilities, Tourette syndrome, seizure disorders, autism spectrum disorders, coordination and motor planning disorders, and organic brain syndrome.

"We try to accept only elementary-age children who have what appear to be the most puzzling, the most severe, the most resistant kinds of school and behavior difficulties," says Trockman, who is also a senior physician with Hennepin Faculty Associates. "We try to start with what seems very complicated to somebody else, so that we can justify the amount of time and energy that we put into an assessment."

The third-grader's school never would have picked up on the seizures, she says. "We see similar situations many times, when children appear to have attention disorders but really have larger problems. When we treat the larger problem, the attention disorder symptoms go away."

In an average year, Trockman estimates that 1,000 children are referred to the clinic by school systems in Hennepin County and the western metropolitan area. From those, they select 100 children whom they think will benefit most from the program, and the rest are referred to other programs.

Developing an Interest in Behavioral Problems

By her own estimate, Trockman has participated in the assessment and treatment of almost 3,000 children with behavior problems in the 26 years she has directed the clinic. If you include her general practice as a pedia-



PHOTOGRAPH BY JOHN NOLTNER

trician, the number of patients Trockman has seen easily exceeds 5,000.

After treating so many children, Trockman could be excused for forgetting details of the lives she has influenced. But she remembers many children with astonishing clarity—including those who first stimulated her interest in development and behavioral issues.

"It was my brothers," says the 55-year-old pediatrician, recalling her earliest efforts at scientific observation. "I was always interested in how the brain worked and how learning took place. With my two brothers, I could see their different learning styles and the struggle that we all had as children. We had different strengths and weaknesses that affected how our schoolteachers regarded us."

Trockman's observations of her brothers, combined with the experience of having two cousins with learning disabilities, piqued her intellectual curiosity. Her interest in behavior and development issues was also encouraged by her father, who taught electrical engineering at the University of Minnesota and talked with her about the challenges of teaching people with different learning abilities.

After completing medical school and a fellowship in pediatric neurology at the University of Minnesota Hospital, Trockman drafted an outline for a program that combined pediatrics, neurology, and special education to help young children who were having behavioral and developmental difficulty in school. She took her ideas to Hennepin County Medical Center, where Richard Raile, M.D., hired her in May 1971. Trockman started her own practice in general pediatrics and also established the Child Behavior and Learning Clinic (CBLC), now one of the region's leading clinics for treating children's behavior and development problems. For more than two decades, Trockman combined her pediatric practice with her administrative responsibilities, but in 1994 she left general practice to concentrate on her work at CBLC.

TROCKMAN continued on page 55

Learning the Language of FATHERHOOD

A first-time father wraps his son in the comfort of words.

BY J. W. BROMFIELD

My father held my newborn son in his arms and gazed out the window to the street. I stood in front of them and watched in awkward silence. My parents had driven three days and 1,300 miles to see their first grandchild, and 20 minutes after my father got out of the car he had run out of things to say.

My son had been born six weeks earlier, and since that time everything my wife and I did revolved around our new child. We talked about our son every waking moment—of which there were many. Diurnal and nocturnal cycles meant nothing to Christopher, who cried nonstop from midnight to 4 a.m., and intermittently the remaining 20 hours of the day. There was little sleep, but lots of talk.

My wife's family visits often. My mother-in-law is a social worker who believes that you can work through any difficulty if you just talk openly about it. When my in-laws visit, you are encouraged to share every feeling and give voice to every thought (even if you have to compete with a screaming baby to be heard).

My family plays by a different set of rules. Here, for the first time in 30 years, three generations were in the same room, and the occasion was marked by silence. For Christopher, this is rare. For my father and me, it is very familiar.

Christopher squirmed in my father's arms. I stared at those arms, which used to be so large and formidable, then my eyes shifted down to his trembling hands.

I knew those hands intimately. They were the hands that had held me as a child and had been raised so often in anger. They were the hands that had poured a thousand Scotch and sodas, and now were so impaired by Parkinson disease that they could barely hold a glass. They were the hands that I had sworn would never touch me again, and now were holding my child.

My wife came into the room. She looked at my father, then me, and frowned. I understood, but I shook my head, caught for a moment between protecting my son and protecting my father. Could my father sense our fear that he might drop the baby?

Finally, I stepped forward and gently lifted my son out of my father's shaking grasp.

"Let me take him from you, Dad."

"OK, my boy," he whispered to me or to Christopher, I couldn't tell.

The light from the street lamp filtered through the blinds with an eerie glow at three in the morning, casting a jagged shadow along my forearms, which were wrapped around my tiny, twisting, screaming boy. I'd been holding Christopher for half an hour. My arms were numb and my ears burned, but I cradled my son close to my chest and sang to him over his screams. I wanted to keep him a little while longer so my wife could get as much sleep as possible before the next breastfeeding.

"Daddy loves you, Mommy loves you, Aunt Maggie loves you," I recited the singsong list, as I had done so many times in recent weeks.

My father never got up in the night with my sisters and me. Whenever my mother sees a crying baby, she makes a remark about how my father stayed in bed all those years while she got up and took care of us. She pretends she's only teasing my father. After 40 years, my mother is still unable to say what she really means.

My father suffers also, although he doesn't acknowledge it. He didn't lose any sleep over his children, but he lost his connection to us. Despite the discomfort and sleep deprivation, a bond is formed between parent and child during these nighttime vigils. This loud, wet, naked screaming thing needs to be comforted, and if you answer the call and hold your child close, the screams will finally cease. It may take months, or years, but eventually your child feels secure in your love and warmth, which (along with



PHOTOGRAPH BY JOHN NOLTNER

"For the first time in 30 years, three generations were in the same room, and the occasion was marked by silence."

a mature digestive system) will carry your child until daybreak.

When angry fathers confront sullen teenagers, perhaps they should keep this image in mind: a tiny, helpless baby cradled in their arms at that odd time between night and morning. How could you hurt a child in whom you had invested so much of yourself?

My wife got up at 4 a.m. and fed our son. Full of milk and comfort, Christopher finally fell asleep. We carried him to our bed and drifted off to sleep ourselves as the sun rose.

It was nine o'clock when we woke up and stumbled into the kitchen. My parents had their coats on and were drinking coffee. Their bags were by the door.

"Your father wants to get back and check on the house," my mother said. "He doesn't like to leave it empty for too long."

I walked out into the cold air and helped my father put the bags in the car. As I wrapped one arm around my father's shoulder, he leaned into me for a moment. Then he asked me the quickest way to 35W. My mother wiped her cheek and told me she loved me.

I waved as their car drove down the alley, then I walked quickly back inside. My wife was on the telephone, talking with her parents. I went into the nursery and picked up my son. Christopher looked up at me briefly then closed his eyes. I smiled, sat him down on my lap, and began to talk. Holding him close, I named all the people in the world who love him. This time I included the man with the trembling hands. "That's your grandfather," I reminded him. "That's my dad." MM

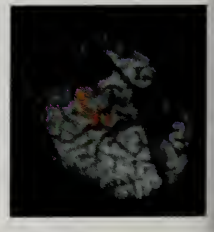
J.W. Bromfield is a medical writer and first-time father who lives in south Minneapolis.

BRINGING up BABY

The nature of nurturing

'U' RESEARCHERS FROM SEVERAL DISCIPLINES ARE COLLABORATING TO STUDY THE COMPLEX ARRAY OF FACTORS THAT SHAPE THE DEVELOPING BRAIN.





You won't find a lot of people on this planet who can talk to you about the 14-3-3 Σ gene of the 17p13.3 chromosome band, should you be so inclined. Not many of us understand single strand conformational polymorphism analysis or think about dC→dT transitions in exon VIII at nucleotide 817. The guy with the microphone at the front of the room—bearded, balding, with a crooked tie and green sports jacket—is one of the few.

But today, Bill Dobyns, M.D., is not talking about molecular genetics. He's doing standup comedy. At a HealthPartners conference on infant and child brain development, he's showing a videotape in which he smacks a baby lightly on each shoulder to demonstrate the baby's equilibrium. "I'm a mean guy. I admit it," he jokes to the crowd of educators and health professionals. "That's why I became a neurologist."

Of course, Dobyns is neither mean nor a comedian. He's one of a handful of people worldwide who daily plumb the depths of genetic structure to understand human brain development, and the conference at which he is delivering his amusing talk is an outgrowth of the tremendous surge of research and media and political attention devoted to the topic. In the past year, a White House conference, cover stories in *Time* and *Newsweek*, and major TV specials have examined infant brain development, detailing the processes of neural migration, synaptogenesis, and the "pruning back" of underutilized neurons. These forums repeatedly emphasize the impact of a baby's environment on this dynamic growth process and advocate measures to stimulate the tender yet robust infant brain.

A surprising amount of this research is being done at the University of Minnesota. And, much like the neurons they study, the university researchers are interlinked, with collaborations spanning departments and specialties. As these connections grow and our understanding of the human brain deepens, disciplines that have often been at paradigmatic odds are finding that nature and nurture are not mutually exclusive, but intricately intertwined.

GENETIC MAPPING PROVIDES CLUES TO DEVELOPMENT

For Dobyns, talking about normal child development for his HealthPartners lecture was a bit of a stretch. The pediatric neurologist and medical geneticist has spent his career researching abnormalities in children—specifically, malformations of cortical development resulting from disorders in neural proliferation, migration, or organization.

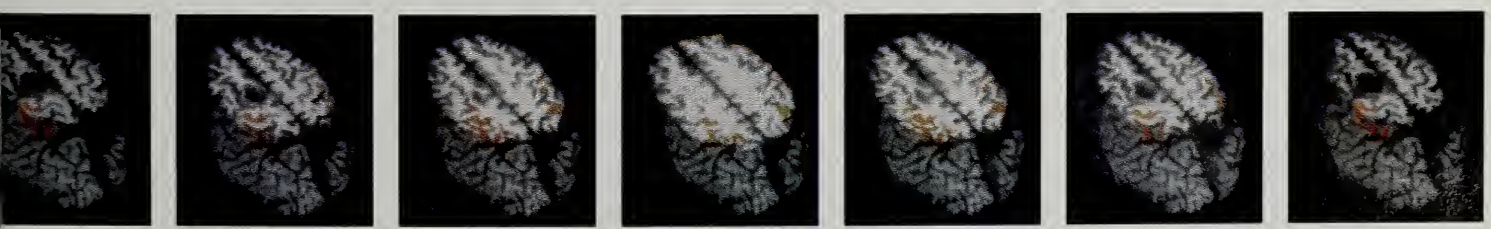
"There are birth defects that fit best into each of these three overlapping categories," says Dobyns. "What I do is essentially learn to delineate ... these different syndromes and then when a clue emerges about the cause, try to find a gene." To date, Dobyns has identified over 30 types of cortical malformation, many of which manifest in classical lissencephaly, or "smooth brain," an absence or paucity of cortical gyri due to incomplete neuronal migration at 9 to 13 weeks gestation.

Dobyns first encountered lissencephaly in 1982 while training at Baylor College of Medicine in Houston. After a decade's work, he confirmed that Miller-Dieker syndrome and some cases of isolated lissencephaly sequence result from deficits in a gene on the short arm of chromosome 17.[1,2] And, with collaborator Elizabeth Ross, M.D., in the university's neurology department, Dobyns is on the verge of isolating a second gene, on the X chromosome, responsible for X-linked lissencephaly and subcortical band heterotopia.[3]

"But once you've found a gene, so what? How does that help you?" asks Dobyns. He notes that the discovery can confirm the cause of a disease and can help with genetic counseling and prenatal diagnosis. "But that's somewhat limited. ... The real big questions once you've found it are, how does it work? I mean, why does it cause this birth defect?"

To answer these questions, Dobyns and Ross have reached out to collaborators beyond the university—an NIH scientist who studies genetically engineered mice with the same defect at chromosome 17 and a researcher

STORY BY DOUGLAS CLEMENT BABY PHOTOS BY JOHN NOLTNER





in Houston who hopes to discover how the defective gene works at the cellular level.

The implications of this work go well beyond lissencephaly and neural migration. "The process by which cells of any type climb, whether they're nerve cells or any other type of cells, is very poorly understood," says Dobyns. "So I think it's almost certain that our work, in addition to helping understand brain development, will shed some light on some very basic mechanisms of cell function.

"It's like throwing a boulder in a pond. The waves are going to be impressive," he adds. "But again, we've got to find the genes first. And so it's one down, one imminent, and many, many more coming."

USING MRI TO DETECT NEURAL DISORDERS

In 1994, as Dobyns prepared to write a review article on neural migration disorders, his obvious choice for coauthor was Charles Truwit, M.D., a pediatric neuroradiologist newly arrived at the University of Minnesota. A year earlier, Truwit had published a paper on Kallmann syndrome, a genetic neural migration disorder that causes reproductive and olfactory dysfunction, in which he used coronal magnetic resonance images to illustrate hypoplasia of olfactory bulbs and sulci.[4] Thirty-six of Truwit's images illustrate the authors' joint article.[5]

MR imaging is a perfect tool for identifying neural migration disorders, and Truwit has continued to work with Dobyns and Ross as they track down their second gene. Truwit has also conducted other brain development research, despite a heavy clinical workload. Working for six years with Leon Kier, a Yale neuroradiologist, Truwit analyzed sagittal MR images of 1,800 humans with normal corpora callosi and 113 patients with abnormal callosi, then dissected over two dozen animal and human brains. Their work debunked the long-held dogma that the corpus callosum develops from front to back in utero.[6,7] "[We've] rewritten the embryology. It's much more likely that [the corpus callosum] grows bidirectionally," says Truwit. Knowing the actual development sequence, he argues, enables radiologists and surgeons to distinguish between destructive lesions and normal growth in infants and adults.

While his research with Dobyns and Kier has relied on structural MR imaging, Truwit's work often involves functional MR imaging (fMRI), both at the university's Center for Magnetic Resonance Research, where he serves as medical director, and at Fairview-University Medical Center. In another research link, Charles Nelson, Ph.D., a professor of cognitive neuroscience in the university's Institute of Child Development and a member of the Medical School faculty, approached Truwit in 1995. He wanted to "see if we could learn something about [child] brain development, the neural bases of that development, memory, cognition, and so forth," Truwit says. Their collaboration, part of a study led by Nelson, used fMRI to observe activation of the prefrontal

cortex of 8- to 10-year-olds during spatial working memory tasks, complementing other research showing activation of frontal gyri during nonspatial working memory tasks.[8,9]

Their work also demonstrates the feasibility of using the noninvasive, high-resolution tool of fMRI for studying brain function in children as young as 4 or 5 years old. "You have to get these kids to hold exquisitely still" in a loud, confining machine, notes Truwit. "But it turns out it's actually doable." In addition to the research goals, Truwit and Nelson point to clinical applications for the technique. "We routinely scan patients for the Minnesota Epilepsy Group," Truwit says. "We do this functional brain imaging to look for the speech centers and for the motor strip prior to either seizure surgery or brain tumor surgery."

TRACKING CHANGES IN NEURAL ELECTRICAL ACTIVITY

Amid the many pictures, charts, and models of human brains that fill Charles Nelson's office sits a photo of an impish, tow-headed 12-year-old boy, his son Colin. As Colin nears adolescence, Nelson may concede that he can't understand him, but it won't be for lack of trying. Colin has been one of his most regular research subjects. Opposite the desk photo, taped to the window behind Nelson's chair, is a 12-paneled MR image of Colin's baby brain. These days, says Nelson, Colin insists on being paid for his contributions to science.

While some of Nelson's projects, like those with Truwit, study children, most focus on infants, a population for whom fMRI technology is inappropriate. This led Nelson to develop and refine the use of event-related potentials (ERPs)—transient changes in neural electrical activity in response to specific, brief stimuli. ERPs provide precise information on the *timing* of neurocognitive processes such as attention and memory, differing from techniques such as positron emission tomography or fMRI, which show the location of those processes. The potentials are recorded using electrodes that are gently attached to infants' scalps. While Nelson's initial studies used only a few electrodes, he is developing caps that will hold far more electrodes—as many as 64 for infants or 128 for adults—for better topographical resolution of the entire scalp.

The amplitude, polarity, and latency of the potentials in response to stimuli—voices or photos of the babies' mothers and strangers, drawings of familiar or novel objects—allow Nelson to study how, when, and where infants process information. Working with Raye-Ann deRegnier, M.D., and Michael Georgieff, M.D., neonatologists at Fairview-University Medical Center, Nelson recently used ERPs to evaluate neural development at age 4 months in 16 healthy infants and 16 infants at risk for neurodevelopmental impairments.[10] By measuring the ERPs generated in response to familiar and novel visual stimuli, the researchers found markedly different patterns in visual recognition memory between the normal and high-risk infants, suggesting that synaptic organization was altered by neonatal events. The results also indicated that ERPs can identify cognitive deficits in very young, preverbal infants.

"We may have in our hands the ability to identify children whose development is compromised far earlier than we've ever been able to do before," says Nelson. "And the earlier you can identify a child, the earlier you can intervene."

Georgieff's research has focused on nutrition and brain development, most recently on prenatal and newborn iron deficiencies. "Sixty-five percent of newborns of diabetic mothers show signs of iron deficiency at birth and 50 percent of growth-retarded babies do," notes Georgieff. By assessing the visual and auditory memory of these infants, he tracks the impact of iron deficiency on hippocampal development. "It allows us to detect them in the newborn period," says Georgieff, "much closer to the time of the insult instead of allowing six or seven years to go by and then trying to figure out how many confounding variables there were."

LINKING PARADIGMS

"Although developmental psychology and developmental neuroscience share interests in common problems," writes Charles Nelson in a recent article, coauthored with *Science* Editor-in-Chief Floyd Bloom, "there has been precious little cross-fertilization between these disciplines."[11] But if the University of Minnesota has a "campus callosum" linking the hemispheres of neuroscience and psychology, it comes in the person of Megan Gunnar, Ph.D., a professor at the Institute of Child Development. Trained as a social developmental psychologist, Gunnar later focused on the psychobiology of stress, specializing, in a word, in spit. Salivary cortisol, as a marker of hypothalamic-pituitary-adrenocorticol activity, serves as an easily obtained stress index. For 17 years Gunnar has used salivary or plasma cortisol to measure stress reactions in infants, children, and animals in response to, among other things, inoculations, parental separation, limb restraint, and circumcision.

In 1994, Nelson and Gunnar measured associations among ERPs, hormonal activity, and emotional behavior in 12-month-old infants.[12] Their study gauged responses to familiar and unfamiliar faces, sampled infants' saliva before and after ERPs and before and after a 30-minute separation from their parent, and evaluated infants' temperaments using a standardized assessment tool. And despite difficulties ("We saw kids just walk right out of the lab, with a head full of electrodes," recalls Nelson), the study empirically demonstrated the rela-



tionship between cognition and emotion long theorized by developmental psychologists.

Much of Gunnar's work has illuminated the stress-mediating role played by psychological attachment to a primary caregiver. One of her studies, for example, found that toddlers who were securely attached to their caregivers reacted less to stressful situations even if the children were behaviorally inhibited.[13]

In 1995, strengthening the connection between University of Minnesota researchers, Gunnar and social psychologist Martha Farrell Erickson, Ph.D., studied 38 infants whose mothers were participating in Project STEEP (Steps Towards Effective, Enjoyable Parenting), a long-term intervention program that Erickson and others developed to promote healthy parent-child relationships. They found that toddlers who had "disorganized or disoriented" attachment relationships with their parents—that is, children without systematic strategies for coping with stress—exhibited far higher cortisol levels than toddlers who did have coherent coping strategies. "The vulnerability of this group of infants to stress may have significant effects on their emotional and social development," concluded the authors. "Frequent stress activation of the neuroendocrine system may play a role in the etiology of affective disorders, particularly depression. Cortisol is known to enter the brain and to have significant effects on neurons in the hypothalamus and hippocampus."[14]

Erickson's primary work, however, has not been biopsychological. Since the early 1980s, she has studied the behavioral impact of mother-child relationships on child development, particularly in at-risk families. In 1991, she became the director of the university's Child, Youth and Family Consortium, an effort to combine university expertise with community resources to address health, social, and education issues facing Minnesota's children and families. The consortium has played a key role in many community initiatives, bridging the often wide chasm between academic research and real-world applications.

Physiological studies of infant/child brain development, including her work with Gunnar, says Erickson, are useful corroboration of what she and other psychologists have long known. "We've been documenting how sensitive parenting leads to secure attachment and good outcomes, psychologically speaking," says Erickson. "And I think the neuroscientists are now demonstrating

that there really is a physiological link there, that the same kind of care that promotes secure attachment also strengthens the synapses in the brain and allows transfer of information and better learning. So I look to that research as further confirmation that what we're trying to do with parents is very important, in ways that we didn't even know before."

A long-term collaborator of Erickson's, Byron Egeland, psychology professor at the Institute of Child Development, puts a more cynical spin on it. "The neurology types are discovering something that the rest of us have known and argued for many years—STEEP is a good example—that stimulation early in life is very important for neurological development," he says. "Well, quite frankly, the first time I heard that was probably in graduate school back in the '60s."

What disturbs Egeland is the focus of some researchers and policymakers on *stimulating* infant minds. He notes, "The most important ingredient to optimal development is not 'stimulating.' ... What's missing in those studies is that it's very important for a young child to establish an attachment with its caregiver so that emotional development can proceed in an optimal fashion. And that forms the basis or the foundation for later learning." Indeed, Egeland and institute colleague Alan Stroufe studied 180 high-risk families for 20 years and found that the quality of a child's early attachment to the primary caretaker is the key predictor of the child's school achievement and of anxiety disorders in childhood and adolescence.[15,16]

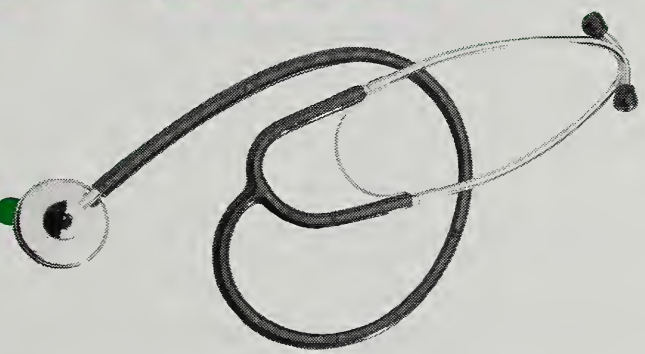
ENCOURAGING HEALTHY PARENTING

Raising smarter, healthier kids will take more than stimulation. What should be done? Is intervention effective? Can doctors play a role? Egeland argues that physicians should encourage healthy, secure parent-child attachment. "Minnesota has some excellent parenting programs," he says. "Pediatricians need to become more involved with [them] because [they] are going to promote more optimal neurological development [see related article, page 20]. It's not a pill. Hey, everybody is looking for a pill to be the answer. It's not."

At the University of Minnesota, scores of clever people are examining the human brain: charting its growth, replicating its flaws, dissecting its parts, measuring its impulses, observing its behavior. Inevitably, some research collaborations will be pruned back, while others will grow stronger through frequent and fruitful use.

www.startribune.com/workavenue

MAKE YOUR ROUNDS ON NEW GROUNDS.





Put your resume on WorkAvenue.com. It's a free, Star Tribune Internet Web site that automatically matches job openings with resumes from people in the health field and other industries. It's free, easy and confidential.* So go to the site. Because we make finding a new job painless.

If you don't have Internet access, send your resume to WorkAvenue.com, Star Tribune, P.O. Box 1617, Mpls., MN 55440-1617. It'll be electronically scanned and placed in the Workavenue.com database. For best results, call 612-673-9012 first.

*The confidentiality feature is only available when you enter your resume on-line.

www.startribune.com/workavenue

Star Tribune
It's where you live.

370073R/7/97

Affiliated
COMMUNITY
Medical Centers, P.A.

Join the security of a large multispecialty group located in Southwest and West Central Minnesota Communities of 3,700 to 19,000. All areas flourish with four-season recreational opportunities, strong economies and excellent education where family and lifestyle are a priority. Outstanding benefits for BE/BC physicians in:

Dermatology
Family Practice
Internal Medicine
Neurology
Ob-Gyn
Orthopedic Surgery

Contact: Janiece Durham
Physician Recruitment Coordinator
Affiliated Community Medical Centers
101 Willmar Avenue SW
Willmar, Minnesota 56201-3591
320-231-6366

Welcome to Your Future

Central Minnesota Group Health Plan will help you meet your practice goals

Dedicated to fostering your well-being and supportive participation in your practice

In-house ancillary services make work more enjoyable

Based in the fast-growing and culturally stimulating city of St. Cloud, only one hour from Mpls/St. Paul

No administrative paperwork, leaving you free to concentrate on medicine

Call Stephanie Jussila, Phys. Services, for information

800•284•3142

E-Mail: stephanie.l.jussila@qm.healthpartners.com

Central Minnesota Group Health Plan
HealthPartners

1245 15th Street North
St. Cloud, MN 56303 • Phone: 612/253-5220

Supported by a three-year grant, for example, Gunnar and Nelson have just launched the Center for the Study of Neurobehavioral Development in the Context of Adversity, which will pair clinical investigators with child development researchers. Gunnar, Nelson, and Dana Johnson, M.D., head of the university's neonatology department, will study adopted Romanian children. Other university researchers are looking at the neurobehavioral effects of lead on children in Minneapolis' Phillips neighborhood and at the impact of maternal anxiety during pregnancy on neonatal outcomes. There is no end, it seems, to the complexity of the human brain, nor to the ingenuity of those who seek to understand it.

Douglas Clement is a free-lance writer in Minneapolis. Brain scans courtesy of Charles Truwit, M.D., and Charles Nelson, M.D., University of Minnesota.

REFERENCES

1. Dobyns WB, Reiner O, Carrozzo R, Ledbetter DH. Lissencephaly: a human brain malformation associated with deletion of the LIS1 gene located at chromosome 17p13. JAMA 1993;270:2838-42.
2. Lo Nigro C, Chong CS, Smith AC, Dobyns WB, Carrozzo R, Ledbetter DH. Point mutations and an intragenic deletion in LIS1, the lissencephaly causative gene in isolated lissencephaly sequence and Miller-Dieker syndrome. Hum Mol Genet 1997;6:157-64.
3. Ross ME, Allen KM, Srivastava AK, et al. Linkage and physical mapping of X-linked lissencephaly/SBH (XLIS): a gene causing neuronal migration defects in human brain. Hum Mol Genet 1997;6:555-62.
4. Truwit CL, Barkovich AJ, Grumbach MM, Martini JJ. MR imaging of Kallmann syndrome, a genetic disorder of neuronal migration affecting the olfactory and genital systems. Am J Neuroradiology 1993;14: 827-38.
5. Dobyns WB, Truwit CL. Lissencephaly and other malformations of cortical development: 1995 update. Neuropediatrics 1995;26:132-47.
6. Kier EL, Truwit CL. The normal and abnormal genu of the corpus callosum: an evolutionary, embryologic, anatomic, and MR analysis. Am J Neuroradiology 1996;17:1631-41.
7. Kier EL, Truwit CL. The lamina rostralis: modification of concepts concerning the anatomy, embryology, and MR appearance of the rostrum of the corpus callosum. Am J Neuroradiology 1997;18:715-22.
8. Truwit CL, Le TH, Lim JC, et al. Functional MR imaging of working memory task activation in children: preliminary findings. Paper presented to the American Society of Neuroradiology, June 1996.
9. Cohen JD, Forman SD, Braver TS, Casey BJ, Servan-Schreiber D, Noll DC. Activation of the prefrontal cortex in a nonspatial working memory task with functional MRI. Human Brain Mapping 1994;1:293-304.
10. deRegnier RA, Georgieff MK, Nelson CA. Visual event-related brain potentials in 4-month-old infants at risk for neurodevelopmental impairments. Dev Psychobiology 1997;30:11-28.
11. Nelson CA, Bloom FE. Child development and neuroscience. Child Dev 1997;68:970-87.
12. Gunnar MR, Nelson CA. Event-related potentials in year-old infants: relations with emotionality and cortisol. Child Dev 1994;65:80-94.
13. Nachmias M, Gunnar M, Mangelsdorf S, Hornik Parritz R, Buss K. Behavioral inhibition and stress reactivity: the moderating role of attachment security. Child Dev 1996;67:508-22.
14. Hertsgaard L, Gunnar M, Erickson M, Nachmias M. Adrenocortical responses to the strange situation in infants with disorganized/disoriented attachment relationships. Child Dev 1995;66:1100-6.
15. Teo A, Carlson E, Mathieu P, Egeland B, Sroufe A. A prospective longitudinal study of psychosocial predictors of achievement. Journal of School Psychology 1996;34:285-306.
16. Warren S, Huston L, Egeland B, Sroufe A. Child and adolescent anxiety disorders and early attachment. J Am Acad Child and Adolesc Psychiatry 1997;36:637-44.

A Healthier Future

Southern Minnesota

Seeking quality primary care trained or emergency medicine physician(s) to practice in ***Blue Earth, Fairmont, Owatonna and Worthington.***

- Stellar Emergency Medicine Practice
- Full-time, regular part-time and moonlighting opportunities
- No restrictive covenants
- Fully accredited CME programs
- St. Paul malpractice insurance
- Competitive bonus, benefit and compensation packages.

ACUTE CARE, INC.

Respond to Melissa Milliken, CMSC, CMSR, Director of Development, 515-964-2772, 800-729-7813 or send CV to P.O. Box 515, Ankeny, Iowa 50021.

Credentialing "What If's"

A Powerful New Tool for Credentialing

- Provides a unique, hands on guide to the skills needed for credentialing
- Shows you how to decrease risk and assure the quality of potential providers
- Includes a step-by-step guide to credentialing processes and procedures

Please call (612)992-3095 for more information

CONTINUING MEDICAL EDUCATION

presented by

ALLINA
HEALTH SYSTEM

Doctors • Hospitals • Health Plans

MARCH, 1998

26-27 ADVANCED LIFE SUPPORT IN OBSTETRICS (ALSO)
Presented by: Allina Health System
Location: United Hospital, St. Paul

APRIL, 1998

15-16 ADVANCED TRAUMA LIFE SUPPORT (ATLS)
Presented by: Allina Health System
Location: United Hospital, St. Paul

MAY, 1998

29-30 CREATING A LATEX SAFE ENVIRONMENT
Presented by: Allina Health System and ELASTIC, Inc.
Location: The Northland Inn, Brooklyn Park

For more information, contact Allina Clinical Education and Research - (612) 992-2424

™ A Trademark of Allina Health System

Visit the Allina CME calendar at http://www.allina.com

Urgent Care



An ***exceptional opportunity*** exists for Urgent Care physicians to practice in the Duluth/Superior area in four clinics within the expanding St. Luke's system. Excellent compensation and benefit package accompanies state-of-the-art facilities.

St. Luke's is a JCAHO accredited, not-for-profit, non-denominational hospital and Level II Regional Trauma Center serving a population of 440,000 people.

Located on the shores of Lake Superior, Duluth is a thriving city within miles of the beautiful northwoods. The area boasts three universities (one with a medical school), cultural centers including symphony, ballet, and theater, four season recreation activities and is the regional medical center for portions of Minnesota, Wisconsin, Michigan and Ontario, Canada.

St. Luke's
Hospital & Regional Trauma Center

Contact Bob Preston
(800) 894-5131
(218) 728-1565 FAX

Physicians Prescribe Parent Education

All parents can benefit from the many programs available to help them with one of life's most challenging jobs.







By Susan Maas

"Parenting is not an instinct" is the catchy title of a brochure touting Early Childhood Family Education (ECFE). It's a statement many people may find surprising; after all, humans have been parenting for many thousands of years.

The phrase signifies a growing recognition that in an increasingly complicated world, new and expectant parents can use a little help. Whether parents are looking for information about infant development, health and nutrition advice, or simply the support of other moms and dads, several parent education programs are available to help make raising children less daunting and more fun.

Physicians are uniquely positioned to connect new and expectant parents with parent education and support. A 1996 survey by the Commonwealth Fund of over 2,000 parents with children age 3 and younger showed that most parents want more information on newborn care,



PHOTOGRAPHS COURTESY OF RON GUSTAFSON, ECFE–ST. PAUL

sleep patterns, toilet training, and encouraging their children to learn. Although physicians usually do not have time to address these issues in depth with their patients, they can act as a trusted link to reputable parenting classes, groups, publications, and other resources.

"Doctors are looked at as authorities. Their word is going to carry a lot of weight," says Betty Cooke, ECFE specialist at the Minnesota Department of Children, Families and Learning. "The first thing they can do is help parents recognize the critical importance of [the parenting] role. And then they can say, 'Here's this program in the community that you should know about.' "

MELD (formerly Minnesota Early Learning Design) and ECFE are two of the most well-known and respected parent education programs in Minnesota. Both group-based programs take a two-pronged approach, providing health and development information along with peer support and encouragement. In today's mobile, less communal society—in which grandparents, aunts, and uncles are often geographically remote—peer support is crucial, says Minneapolis neonatologist Bonnie Landrum, M.D., who extols the benefits of parent education to mothers and fathers of her preemie patients.

"Families are scattered," Landrum says. "You don't have that education piece that used to be internal in extended families; you don't have the role models."

Pediatrician Terence Coyne, M.D., agrees. He adds that while many child-rearing books offer reassurance, they can't replace face-to-face conversation. "It's comforting when you know that other 2-year-olds have temper tantrums," Coyne says. "It's just good to share the experience." In support groups, parents can be honest about their frustrations and not worry about being judged by other participants. They can also exchange morale-boosting pats on the back.

The information provided in the programs is meant to be just that: information. The idea is not to tell people how to raise their children, but to provide them with a sound developmental context, says Ron Gustafson, community coordinator of ECFE for St. Paul Public Schools. Many parents are intrinsically equipped for the job but feel overwhelmed by the confusing array of child development research—and the often-conflicting "expert advice"—pitched at them daily.

"We give clear information in practical terms," Gustafson says. "The program gets them on a track where they feel confident, they feel informed, and they tend to see development that is positive. And this becomes a positive, self-reinforcing experience."

Jennifer Paist, manager of products and services

for MELD, describes a similar perspective. MELD literature emphasizes that the organization does not promote a political, social, or religious agenda, but rather aims to expose parents to a range of child-rearing options, allowing them to make informed choices based on solid scientific and social research. "We really focus on making parents more confident in themselves and their abilities to raise their kids successfully," Paist says.

Studies have shown that parents who participate in MELD are at lower risk for abusing and neglecting their children. One study of teen mothers in MELD groups showed that the young women were 23 percent less likely to become pregnant again than their peers who did not participate. Yet while parent educators always strive to reach more high-risk families, they also work to change the perception that their programs are strictly for parents who are poor, young, uneducated, or who were abused as children.

In the early years of ECFE, which began in 1974, people often made wrong assumptions about the program, Cooke says. "In many rural communities especially, people thought, 'This is only for people who have a problem.' " But, she asserts, "*Everybody* can benefit. It crosses all walks of life." You might be the most knowledgeable, the most educated person in the world, Cooke says, but parenting is a challenge unlike any other.



Jerome Kwako, M.D., a Duluth pediatrician, notes that parents of special-needs children may be more likely than others to seek out education and support. "If kids

HCMC's Teen Parent and Pregnant Teen Clinics

Parenting is a weighty challenge—and so, for that matter, is being a teenager. Combine the two roles and the odds aren't promising. A study published in the November journal *Pediatrics* showed that children born to teenage mothers are far more likely to drop out of high school, live in poverty, and become teen parents themselves. However, the right kind of help can make a critical difference, both for a teenage mom and her child.

The programs for pregnant teens, teen parents, and their infants at Hennepin County Medical Center are a model of success. Charles Oberg, M.D., who with pediatric nurse Kay Bilger, R.N., directs the Teen Parent Clinic at HCMC, attributes that success to an emphasis on continuity of care.

Oberg, interim chief of pediatrics and senior vice president of Hennepin Faculty Associates, believes that teens who 20 years ago might have "gotten lost in the system" today are receiving the care they need in the short term and the support they need for the long haul. The Teen Parent Clinic is part of a comprehensive system at HCMC that also includes the Pregnant Teen Clinic, a more general adolescent health clinic, and a Pregnant Teen Group.

One goal of the programs is preventing or postponing subsequent (or first) pregnancies so that teens can pursue educational and career goals and become self-sufficient—and not coincidentally, good parents. "The teen parent is really at a crossroads. This is very much a vulnerable, high-needs, high-risk population," Oberg says. At HCMC, a multidisciplinary team that includes a physician, nurses, nurse midwives, a social worker, and sometimes a psychologist connect with the patient early on, following her through her pregnancy and beyond. Occasionally, the team pulls in other specialists, such as a nutritionist.

Typically, Pregnant Teen Group meetings, facilitated by obstetric nurse Ellen Standing, R.N., are linked with patients' prenatal care visits to the Pregnant Teen Clinic. During the roughly hour-long, informal sessions, teens learn about pregnancy and newborn care, ask

have cerebral palsy, learning disabilities, attention deficit disorder, diabetes ... there's a huge number of groups that are tremendously helpful—just *vital*," Kwako says. MELD and ECFE also serve parents with special needs or circumstances.

But as a physician and a father, Kwako feels that families of healthy children—even families who are financially and emotionally secure—can also gain from parenting programs. "We can always learn throughout our lifetime," Kwako says. He and his wife, Jean, participated in a parent support group, and they believed so strongly in its benefits that Jean ended up facilitating a group for several years.

When patients with young children express problems or concerns, Kwako does his best to help address the issues at hand—then he reminds them about resources he probably mentioned once before. "I take out my prescription pad and I write down names and phone numbers of parent support groups," he says.

A report published in 1996 by Carnegie Corp. looked at positive outcomes for families who participate in parent education. Citing ECFE as an exemplary program, the report showed that preschoolers whose parents take part in family support and education show IQ gains that persist into elementary school.

Neonatologist Landrum says people who may be fine parents without help or reinforcement could be *outstanding* parents with it. "Who wants adequate? You always want to do the best possible job at everything, and this is the most important job there is."

Finding a Parenting Program That's Right for Your Family

To find out about early childhood and parent education classes in their areas, parents can call their local community education programs and ask what's offered.

Early Childhood Family Education (ECFE) is available in school districts throughout Minnesota. It offers a variety of programs of different duration. Families can participate for a quarter, a semester, or a year. Enrollment costs are based on a sliding scale and vary somewhat by school district. Most programs are held two hours a week.

MELD groups typically meet weekly or twice a month for two years. Meetings are facilitated by at least two parents who are experienced volunteer facilitators. There are no fees for any of the MELD groups. For more information, call 612/332-7563. MM

Susan Maas is a writer at the Minnesota Medical Association.

questions of obstetric and pediatric nurses, and discuss fears or concerns.

"We welcome them to bring partners, parents, grandparents to the meetings," Standing says. Topics of discussion include breast-feeding, healthy diet, drugs and alcohol, and vaccination. Frequently, a teen who has had her baby will come back and visit the group to share her thoughts about the joys and hardships of parenting.

Informing teens about birth control and encouraging its use is a critical aspect of the programs, but it's only one piece. Facilitators also emphasize the importance of school—not only high school, but postsecondary education. Since many of the patients receive medical assistance, staying in school is essential, Oberg says; welfare reform has made it a requirement for teens to be eligible for aid. Staying in school is important for the mother's and the child's long-term stability and fulfillment, he adds.

Though both Oberg and Standing say some of their teen patients become pregnant again, many do not. No formal studies have been done to measure the programs' outcomes, but, says Oberg, "our clinical impression is that we are reducing subsequent births." And he estimates that by the time the child of a teen involved in the programs is 2 years old, he or she will have had 20 percent to 30 percent more visits with health care professionals than most children of teen parents. Perhaps more important, the child and mother have had ongoing support from the same group of caring practitioners.

Several patients who were pregnant teens at the programs' inception a decade ago have continued to see the same physicians and nurses over the years. "We have patients in their 20s still coming—they have careers in nursing, computer science, cosmetology," Oberg says. A large percentage of teens in the programs indicate an interest in health care-related careers. Is that a coincidence? "They look at us as a source of support for them. ... I think it may be social modeling." –*SM*

COMMENTARY

CLOSE TIES *to Parents, School* IMPROVE *Adolescents'* LIVES

By Michael D. Resnick, Ph.D.

An author of the landmark "Protecting Adolescents from Harm" study outlines the findings and describes public response.

MANY PARENTS FEAR that once their children hit adolescence, adults no longer have much impact on them. Accepting the idea that they no longer matter, some parents surrender their teens to the power of the peer group. While many adolescents are quite effective in convincing us that we have become irrelevant in their lives, too often adults make the mistake of *believing* them.

Parents, take heart. According to a nationally representative sample of adolescents, what parents and teachers say, do, believe, or expect of young people does make a difference. "Protecting Adolescents from Harm: Findings from the National Longitudinal Study of Adolescent Health" (*Journal of the American Medical Association,* September 10, 1997) is the first report of the federally funded National Longitudinal Study of Adolescent Health (Add Health), the largest, most comprehensive study of adolescent health and behavior ever undertaken. Among the report's key findings:

• For adolescents, a strong sense of connection to parents and family—feelings of closeness, warmth, love, and caring—was protective against emotional distress, suicidal thoughts, violence, substance use



PHOTOGRAPH BY TERRY GYDESEN

(including cigarette, alcohol, and marijuana use), and early sexual activity. This applied after controlling for the effects of gender, race, ethnicity, family structure, and poverty status. The sense of connectedness to parents and family was even more important than parental presence at key times, such as waking, after school, dinner, and bedtime.

• While family can provide nurturance and support, home can be a source of considerable risk as well. Adolescents who reported easy access to firearms at home (close to one-quarter of the sample) were significantly more likely to be involved in suicide attempts and interpersonal violence. Young people who perceived easy access to cigarettes, alcohol, and marijuana in the home were more likely to use those substances than were peers who did not report easy access.

• A sense of connectedness to school was protective against nearly every risk behavior examined. School connectedness meant that students felt a sense of belonging and perceived teachers as fair and caring. School connectedness was associated with better emotional health, less substance use, less interpersonal violence, and later age of first intercourse. These findings contradict the common belief that young people's health at school is influenced most strongly by school characteristics: student-teacher ratio, type of school, and policies and regulations (such as those governing substance use or violence).

• The study also challenged the assumption that employment makes teens healthier and happier. Adolescents who worked 20 or more hours per week for pay during the school year (close to one in five students in 9th through 12th grade) reported more emotional distress; they also smoked more, drank more, and were more likely to have sex at an earlier age.

Publication of this first Add Health report resulted in a whirlwind of media interest, with newspaper, radio, and television coverage. While a handful of editorials dismissed the findings as merely a restating of the obvious or as common sense, callers to radio talk shows and dozens of E-mails from parents of teenagers expressed something different—relief, optimism, a sense of validation, and outright thanks.

Parents told us it's affirming to hear that their values, expectations, and connections with their children *were* important. Many expressed concern and frustration about

the difficulty of juggling family and work responsibilities and appreciated the clear, unequivocal message that parents and family do matter. A number of people who called or wrote were single parents who felt barraged by societal messages that they were somehow damaging their children's development. It is clear that people want information about protecting and promoting the health and well-being of adolescents.

Many health practitioners also raised questions about the implications of the study's findings for their work with adolescents and families. Certainly, the results suggest that assessments of home and family life need to be comprehensive—including questions about access to guns, alcohol, tobacco, and illicit substances—and that practitioners should ask adolescents about employment and their sense of connection to school.

This first Add Health report was the result of more than a year's effort from an interdisciplinary team of investigators from three schools (Medicine, Nursing, and Public Health) in the University of Minnesota's Academic Health Center. The team included Linda H. Bearinger, Ph.D., M.S., Trisha Beuhring, Ph.D., Robert W. Blum, M.D., M.P.H., Ph.D., Marjorie Ireland, Ph.D., Michael D. Resnick, Ph.D., Marcia Shew, M.D., M.P.H., and Renee E. Sieving, Ph.D. The goal of the study was twofold: to introduce broad findings from a nationally representative sample of adolescents in grades 7 through 12 and to help frame public discourse about adolescents in terms of health promotion and protection rather than problems.

"Protecting Adolescents from Harm" is just the first of numerous analyses that will be conducted on this rich and complex data set over the next several years. The principal Add Health investigator, J. Richard Udry, Ph.D., of the University of North Carolina, Chapel Hill, has also made the data available to the general community of researchers across the country (for more information, see box above).

For more information ...

Reprints of "Protecting Adolescents from Harm" are available by E-mail: resni001@tc.umn.edu.

Information about the National Longitudinal Study of Adolescent Health is available on the World Wide Web at: http://www.cpc.unc.edu/addhealth.

The National Longitudinal Study of Adolescent Health enables us to understand the determinants of adolescents' health using a national sample. Moreover, framing our questions in terms of health promotion—looking at resilience, protective factors, and the experiences that make a positive difference in the lives of young people—offers the potential for discovering information that will inform policies, programs, and practices. MM

Michael Resnick is professor of pediatrics and director of the National Teen Pregnancy Prevention Research Center at the University of Minnesota–Minneapolis.

Opportunities in Urgent Care

- Locations in Shakopee and Chaska
- Family Practice, Emergency Medicine and Internal Medicine with pediatrics experience
- Second and third year residents and practicing physicians.
- FT and PT positions available, with benefits. Evening and weekend hours. Moonlighting also available.

St. Francis Regional Medical Center
jointly sponsored by the Benedictine and Allina™ health systems

Debbie Modder
Allina Health System
Route 80775
5601 Smetana Drive
Minnetonka, MN 55343
612-992-3094/800-248-4921
Fax: 612-992-2927

Building Assets

A Positive Approach to Adolescent Health

A Minneapolis research organization helps communities move beyond "fixing problems" among youth to giving them the tools and support they need.

Nancy Leffert, Ph.D.

Editor's Note: *This fall, the Minnesota Medical Association honored the Maple River Community Network with a Stop the Violence Award for its grassroots efforts to promote a strong antiviolence message in four rural Minnesota communities.*

When community leaders from four small towns in southern Minnesota saw the results of a survey of area adolescents, they became alarmed—too many youth were using alcohol and other drugs. The survey, "Search Institute Profiles of Student Life: Attitudes and Behaviors," assesses young people's risk behaviors as well as perceived assets such as family support. Armed with the survey information, residents from the four towns that make up the Maple River Community Network—Amboy, Good Thunder, Mapleton, and Minnesota Lake—turned out in record number to a town hall meeting to talk about the problems. Parents complained of bullying among young people. Students shared their concerns about the verbal abuse and fighting they witnessed on and off school grounds. Some residents no longer felt safe in their homes and were afraid to go out at night.

The Maple River Community Network faced a number of tough questions. What was the best way to address adolescent substance abuse and other concerns voiced by community members? Should the towns hire more police officers? Should schools expand their drug prevention and education programs? Should the network try to identify and work with at-risk children? Should the community implement some combination of programs and policies?

These problems are by no means unique. The media resounds with reports of adolescent drug and alcohol abuse, youth violence, children saddled with adult responsibilities, and the lack of useful roles for our youngest citizens. For example, a weekly news magazine recently featured a cover story about heroin use among adolescents, reporting that heroin is fast becoming the drug of choice among students at upper-middle class high schools.

Searching for Solutions

One thing the Maple River Community Network and similar community organizations across the country know for sure is that the issues are complex and demand sophisticated, multipronged solutions. Adding to the confusion is a bewildering array of approaches to treatment or prevention of drug abuse and other problems, as well as models for promoting healthy behavior. Some options are:

- targeted prevention to reduce or control negative behaviors;
- early interventions, such as HeadStart, which seek to give young children a leg up;

continued

Selected Maple River Survey Results

The Maple River Community Network survey revealed, among other things, that:

- 30 percent of young people used alcohol once or more in the last 30 days;
- 45 percent had attended a party where other kids their age were drinking;
- 43 percent had ridden once or more in a car in which the driver had been drinking;
- 13 percent had used illicit drugs in the last year;
- 14 percent felt sad or depressed most of the time during the last month;
- 14 percent felt strain, stress, or pressure during the last month;
- 4 percent tried to commit suicide two or more times;
- 51 percent had gotten into trouble at school;
- 19 percent had stolen something from a store;
- 14 percent had gotten into trouble with the police;
- 16 percent had committed an act of vandalism.

40 Developmental Assets

	ASSET TYPE	ASSET NAME	DEFINITION
EXTERNAL ASSETS	SUPPORT	1. Family support	Family life provides high levels of love and support.
		2. Positive family communication	Young person and her or his parent(s) communicate positively, and young person is willing to seek parent(s) advice and counsel.
		3. Other adult relationships	Young person receives support from three or more non-parent adults.
		4. Caring neighborhood	Young person experiences caring neighbors.
		5. Caring school climate	School provides a caring, encouraging environment.
		6. Parent involvement in schooling	Parent(s) are actively involved in helping young person succeed in school.
	EMPOWERMENT	7. Community values youth	Young person perceives that adults in community value youth.
		8. Youth given useful roles	Young people are given useful roles in the community.
		9. Service to others	Young person serves in the community one hour or more per week.
		10. Safety	Young person feels safe at home, school, and in the neighborhood.
	BOUNDARIES AND EXPECTATIONS	11. Family boundaries	Family has clear rules and consequences, and monitors the young person's whereabouts.
		12. School boundaries	School provides clear rules and consequences.
		13. Neighborhood boundaries	Neighbors take responsibility for monitoring young people's behavior.
		14. Adult role models	Parent(s) and other adults model positive, responsible behavior.
		15. Positive peer influence	Young person's best friends model responsible behavior.
		16. High expectations	Both parent(s) and teachers encourage the young person to do well.
	CONSTRUCTIVE USE OF TIME	17. Creative activities	Young person spends three or more hours per week in lessons or practice in music, theater, or other arts.
		18. Youth programs	Young person spends three hours or more per week in sports, clubs, or organizations at school and/or in community organizations.
		19. Religious community	Young person spends one or more hours per week in activities in a religious institution.
		20. Time at home	Young person is out with friends "with nothing special to do," two or fewer nights per week.
INTERNAL ASSETS	COMMITMENT TO LEARNING	21. Achievement motivation	Young person is motivated to do well in school.
		22. School engagement	Young person is actively engaged in learning.
		23. Homework	Young person reports doing at least one hour of homework every school day.
		24. Bonding to school	Young person cares about his or her school.
		25. Reading for pleasure	Young person reads for pleasure three or more hours per week.
	POSITIVE VALUES	26. Caring	Young person places high value on helping other people.
		27. Equality and social justice	Young person places high value on promoting equality and reducing hunger and poverty.
		28. Integrity	Young person acts on convictions and stands up for her or his beliefs.
		29. Honesty	Young person tells the truth even when it is not easy.
		30. Responsibility	Young person accepts and takes personal responsibility.
		31. Restraint	Young person believes it is important not to be sexually active or to use alcohol or other drugs.
	SOCIAL COMPETENCIES	32. Planning and decision-making	Young person knows how to plan ahead and make choices.
		33. Interpersonal competence	Young person has empathy, sensitivity, and friendship skills.
		34. Cultural competence	Young person has knowledge of and comfort with people of different cultural/racial/ethnic backgrounds.
		35. Resistance skills	Young person can resist negative peer pressure and dangerous situations.
		36. Peaceful conflict resolution	Young person seeks to resolve conflict non-violently.
	POSITIVE IDENTITY	37. Personal control	Young person feels he or she has control over "things that happen to me."
		38. Self-esteem	Young person reports having high self-esteem.
		39. Sense of purpose	Young person reports "my life has a purpose."
		40. Positive view of personal future	Young person is optimistic about her or his personal future.

©Search Institute, 700 South 3rd Street, Minneapolis, MN 55415, 612-376-8955

Search Institute

Since 1989, Search Institute has conducted in-depth studies of more than 400,000 students in grades 6 through 12 in communities across the country. The 156-item survey, "Search Institute Profiles of Student Life: Attitudes and Behaviors," measures several constructs, including developmental assets and deficits and high-risk behaviors. Search Institute administers the confidential surveys and generates a report based on the results for the school district or community surveyed.

On the survey, students are asked questions or asked to agree or disagree with statements such as, "I get along well with my parents" or "My parents give me help and support when I need it." Some other examples from the questionnaire include:

- "How many times in the last 2 years have you been the victim of physical violence where someone caused you physical pain or injury?"
- "During the last 12 months, how many times have you been to a party where other kids your age were drinking?"
- "During the last 12 months, how many times have you gotten into trouble with the police?"
- "During an average week, how many hours do you spend helping friends or neighbors?"
- "What grades do you earn in school?"

Search Institute has developed the Healthy Communities, Healthy Youth initiative to find ways to implement the developmental assets identified in the survey. The institute is working with the Minnesota Academy of Family Physicians, led by Ken Kephart, M.D., to determine whether family physicians can contribute to this effort. One possibility is to modify the questionnaire for use in physicians' offices.

- treatment for children and youth who have diagnosed problems; and
- promotion of opportunities and relationships that lead to healthy development into adulthood.

The first three approaches are "problem-focused"—they aim to fix or prevent a problem. The traditional response to social issues involving young people is to name the problem—such as violence, school dropout rates, teen pregnancy, alcohol and drug abuse—and then develop strategies for treatment. Typically, programs are carried out by social workers, psychologists, physicians, and other social service professionals. Unfortunately, researchers, clinicians, educators, and parents have found that many traditional strategies used to treat adolescent problem behaviors have yielded disappointing results—either they don't work or they lack "staying power."[1,2] Thus, while these efforts are important, community members must also ask, "Are we doing enough?"

Fixing problems is *not* enough, asserts Karen Pittman, a researcher from the Center for Youth Development and Policy Research in Washington, D.C. "Problem-free is not fully prepared," she writes. She and other youth advocates believe that we need to move beyond the "problem" paradigm toward a positive youth development approach that seeks to provide the "tools, skills, and training that young people need to become contributing members of the community."[3]

Moving beyond a focus on problems does not mean that we do nothing about the rise of adolescent drug abuse or that we ignore the fact that many children go to school every day without breakfast. There will always be a need for services, treatments, and interventions. But, increasingly, people who work with youth are also asking what tools and support young people need to grow up healthy.

Search Institute's Assets Model

Search Institute's "asset-building" approach is one example of this shift in thinking. Search Institute, a Minneapolis-based research organization that focuses on children and youth, bases its model's intellectual underpinning on studies of resilience. In examining the lives of youth growing up under extremely disadvantaged conditions, researchers found that some individuals escaped without serious damage; these young people were described as "invulnerable," "stress-resistant," "hardy," or "resilient."[4] Emmy Werner and her colleagues asked questions about this group, with the idea that understanding resiliency could lead to successful prevention efforts.[4,5]

This line of research has shown that some individuals are more resistant to stress than others, but even resilient youth can be overwhelmed by stress. Researchers also found that people are not necessarily born "stress-resistant."[4] Instead, several factors appear to protect young people from severe, long-term damage resulting from adverse conditions. For example, children who experience chronic adversity have better outcomes if they have positive relationships with competent adults, are good learners and problem solvers, are engaging or liked by others, and have a sense of competence or self-efficacy.[6]

This research had practical applications, since, to some extent, these protective factors can be "manipulated" in the environment. For example, researchers J. David Hawkins and Richard Catalano Jr. developed a positive youth development model that promotes positive protective factors to reduce the risk of substance abuse.[1]

Search Institute's asset-building model has similar goals. Search Institute has identified 40 developmental

assets, organized into eight broad categories, including commitment to learning, positive identity, support, empowerment, and constructive use of time (see page 28). We know through our study of more than 400,000 adolescents that these developmental assets inoculate youth from high-risk behaviors, including substance abuse and delinquency. The more assets young people have, the less likely they are to engage in problem behaviors—and the more likely they are to grow into healthy and productive adults.[7,8]

Family, school, and community provide the context and means for youth to develop these important assets. For example, since the survey was administered in the Maple River communities, citizens have actively worked at providing supportive contexts for their children and youth. With technical assistance from Region Nine Prevention and Healthy Communities, and working at a grassroots level, the network sponsored an antiviolence awareness campaign, held neighborhood block parties, conducted walking tours of their towns, sponsored parent education classes and workshops, and integrated senior citizens into prevention activities. These activities and others like them are excellent examples of how real people and real communities can make a difference in raising healthy children and youth. MM

Nancy Leffert is a research scientist at the Search Institute in Minneapolis.

Maple River survey results are used with permission of the Maple River Community Network.

REFERENCES

1. Hawkins JD, Catalano RF. Communities that care: action for drug abuse prevention. San Francisco, California: Jossey-Bass, 1992.
2. Hawkins JD, Catalano RF, Miller JY. Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. Psychol Bull 1992;112:64-105.
3. Pittman KJ, Cahill M. A new vision: promoting youth development. Washington, D.C.: Center for Youth Development and Policy Research, Academy for Educational Development, 1991.
4. Rutter M. Resilience: some conceptual considerations. J Adolesc Health 1993;14:626-31.
5. Werner EE, Smith RS. Vulnerable but invincible: a longitudinal study of resilient children and youth. New York: Adams Bannister Cox, 1982.
6. Masten AS, Best KM, Garmezy N. Resilience and development: contributions from the study of children who overcome adversity. Development and Psychopathology1990;2(4):425-44.
7. Benson PL. The troubled journey. Minneapolis, Minnesota: Search Institute, 1990.
8. Benson PL. All kids are our kids: what communities must do to raise caring and responsible children and adolescents. San Francisco, California: Jossey-Bass, 1997.

Physicians of Greater Minnesota

If you are a physician who:

- is in a practice that is not aligned with a health system or major payer
- believes that the economics of medical practice are changing
- believes that medicine will become more competitive and value driven
- wants to preserve the values and professional rewards of private practice
- is interested in learning more about a physician-owned and -governed organization dedicated to strengthening physicians in private practice

We invite you to call...

(320) 202-0440

Nelson Sirlin, MD, Medical Director
Steve Gerberding, MHA, Executive Director

THE Minnesota CLINIC

Your Partner in Quality Health Care

30 Sixth Avenue South
St. Cloud, MN 56301
Bus: 320-202-0440
Fax: 320-202-0422
Visit our website: www.mnclinic.com

Achieving Universal Health Care Coverage for Children

The Minnesota Experience

Minnesota has made major strides toward ensuring every child has access to health insurance.

Charles N. Oberg, M.D., M.P.H., and Deborah Chase, M.P.A.

With Congress recently enacting the State Children's Health Insurance Program (KidCare), renewed attention has been given to the problem of uninsured children. Minnesota offers a successful example for the nation. After two decades of effort, Minnesota's various health reform initiatives have propelled the state to a 97 percent insured rate for children.[1] We discuss the many steps taken to reach this point, as well as current and future challenges.

To achieve universal access for children, Minnesota has used a broad array of methods, including Medicaid expanded access, insurance reform, and waivered services. The specific initiatives we examine include state-sponsored insurance programs, such as the Children's Health Plan and MinnesotaCare; health insurance reform through the Minnesota Comprehensive Health Association (MCHA) and the Children's Health Insurance Reform Proposal; Medicaid eligibility expansions; and a series of Medicaid waivers received from the federal government.

Expanded Access to Care: Broadening Eligibility

Children's Health Plan

In 1985, an estimated 450,000 Minnesotans were without health insurance; of these, 100,000 were children.[2] At that time, the state was unable to expand Medicaid for many of these children because of federal eligibility restrictions. In 1987, Minnesota created a state insurance program, Children's Health Plan, for children who were either uninsured or underinsured. The program covered children between the ages of 1 and 18 years (1 to 8 until 1991). It initially covered primary and outpatient health services, such as medical and dental checkups, vision care and prescription eyeglasses, emergency room care, outpatient surgeries, and a limited number of mental health services. The program was not designed to cover inpatient hospitalizations, long-term care, or chemical dependency treatment. However, if these services were needed, families often became eligible for Medicaid through the spend-down provisions (i.e., paying out-of-pocket for services and then meeting Medicaid income standards).

Children were eligible if they were Minnesota residents with family incomes less than 185 percent of the federal poverty guideline (FPG) and they were currently uninsured. Families paid an enrollment fee of $25 per child per year for health plan coverage. The program was so successful that it has served as a model for other states, including New York, which enacted its own statewide Children's Health Plan in 1991.

MinnesotaCare

Children's Health Plan evolved into the MinnesotaCare program. In response to national and state interest in reducing the number of uninsured individuals, the Legislature created the Minnesota Health Care Access Commission in 1989 to develop a blueprint for universal access to health care.[3] The commission presented its report to the Legislature in 1991, and in 1992, the Legislature passed the HealthRight Act based on many of the commission's principles. The state-subsidized health insurance program within HealthRight, named MinnesotaCare, built upon the success of and replaced the Children's Health Plan. MinnesotaCare began enrolling families on October 1, 1992. The program was originally funded through a 2 percent provider tax,* a cigarette tax (FY 1992-93 only), a 1 percent tax on premiums of HMO and nonprofit health service plans† (e.g., Blue Cross and Blue Shield of Minnesota and Delta Dental),

* The 1997 Legislature reduced the provider tax to 1.5 percent for services rendered on or after January 1, 1998. The reduced rate will apply for calendar years 1998 and 1999 and possibly longer if the Health Care Access Fund is projected to have a positive annual balance for FY 2001.

† The 1997 Legislature repealed the 1 percent nonprofit health service plan/HMO premium tax for FY 1998-99 and longer if the Health Care Access Fund has an annual surplus.

and enrollee premiums. It is designed to cover the uninsured who are not poor enough to qualify for Medicaid or General Assistance Medical Care (a state-operated and -subsidized program for poor, vulnerable adults) and who do not receive health insurance through their employer.

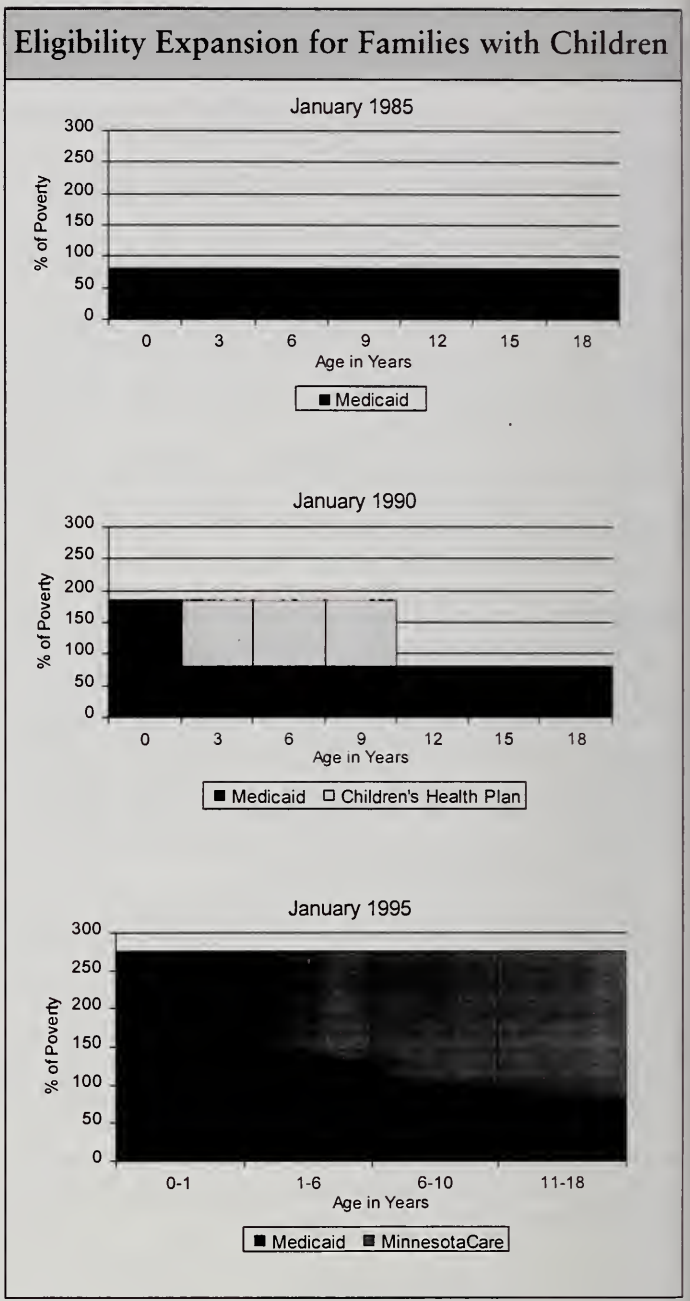
Permanent Minnesota residents are eligible for MinnesotaCare if they are not eligible for Medicaid or GAMC, have been uninsured for at least four months, and have not had access to employer-sponsored health insurance in the preceding 18 months. Those currently eligible are uninsured families with children who are below 275 percent of the FPG and adults without children who are below 175 percent of FPG. As of July 1996, the program has provided coverage to close to 100,000 Minnesotans, 44,780 of whom were children under age 18.

In 1994, the state declared its intent to achieve universal health care coverage by 1997. In 1995, however, budget and political pressures forced a change in policy. The new goal is to achieve an uninsurance rate of less than 4 percent of the total Minnesota population by the year 2000.[4] The state defined universal coverage as 1) every Minnesotan has access to a full range of quality health care services; 2) every Minnesotan is able to obtain affordable health coverage that pays for the full range of services, including preventive and primary care; and 3) every Minnesotan pays into the health care system according to his or her ability.

Medicaid expansion

For 30 years, the United States has guaranteed health insurance for its poorest residents. Begun in 1965, the national Medicaid program provides health care coverage to very low-income individuals. It is funded by a combination of federal and state dollars, which vary depending on the state's per capita income. The federal share ranges from 50 percent to 80 percent of Medicaid expenditures. In Minnesota, 52 percent of Medicaid expenditures are funded by the federal government and the remaining 48 percent are funded by the state. Although some covered services vary by state, the federal government mandates a core set of benefits, which includes inpatient and outpatient hospital care; physician, midwife, and certified nurse practitioner services; laboratory and x-ray services; nursing home care and home health visits; child and teen checkups; family planning; and care in rural health clinics/federally qualified health centers.[5] States have the option of covering an additional 33 services for which they still receive federal matching funds. Minnesota offers 31 of these 33 services and ranks first when compared with other states.[6]

The figure demonstrates that as of January 1985, Medicaid was limited to 133 percent of the AFDC eligibility standard, which resulted in coverage for those children and families with incomes less than 80 percent of the federal poverty level. For infants under age 1 and women in need of prenatal care, eligibility was increased to 185 percent of the federal poverty level, enacted as the



FIGURE

first of several Medicaid eligibility increases in 1987, known as the Minnesota Prenatal Care Initiative. Eligibility for Medicaid had always varied depending on age and health condition. However, by 1995, Minnesota secured through a federal waiver Medicaid expansion up to 275 percent of poverty for pregnant women and children under age 1. In addition, children 2 to 5 years of age must be covered at or below 133 percent of poverty, and children 6 to 11 at or below 100 percent of poverty.

Because of expanded eligibility, Minnesota's Medicaid program has grown and now covers about one-tenth of Minnesotans. In 1991, 9.5 percent of Minnesota residents and 15 percent of kids were on Medicaid, compared with a national average of 10.7 percent and

UNIVERSAL COVERAGE continued on page 41

Announcements

Minnesota Medicine Lauded by Peers

Minnesota Medicine won four awards—including best overall magazine for association publications—in the first annual Minnesota Magazine Excellence Awards. Besides taking the top award in its division, *Minnesota Medicine* also won:

- Best feature article, association publications, for Doug Clement's February 1997 article "Healing the Wounds of War";
- Best service piece, association publications, for a November 1996 article by editor-in-chief Charles Meyer, M.D., entitled "Let's Go Surfing: A Physician Guide to the Internet"; and
- Best feature design, association publications, for the June 1997 article "Healing Arts for Performing Artists," designed by Susan Rodsjo.

The competition is sponsored by the Minnesota Magazine Publishers Association, a trade group of more than 100 publishing, printing, and prepress companies.

• • •

Mark Your Calendar for '98 CPT Coding Seminars

Several workshops on CPT coding updates, RBRVS updates, and new evaluation and management guidelines are slated for January. Registration for each workshop is 8 a.m.; sessions run from 8:30 a.m. to 4:30 p.m. Dates and locations are: January 6, Sheraton Midway, St. Paul; January 8, Holiday Inn, Duluth; January 13, Kelly Inn, St. Cloud; January 15, Marriott, Bloomington; and January 20, Holiday Inn, Mankato. The cost for each seminar is $149; for more information, call Vicki Westling at the MMA, 612/362-3764 or 800/342-5662.

The Monitor

News For Minnesota Physicians

MMA Seeks Solutions to Physicians' Concerns

To address issues that could have a negative impact on physicians and their patients, the Minnesota Medical Association has been working closely with other organizations.

Medica Fee Schedules

The MMA has expressed concern about Medica's new modified fee schedule for diagnostic imagining procedures, which took effect November 15. The schedule provides a list of CPT codes for which a clinic will be reimbursed at the current rate, as well as a list of codes for which that specialty will be reimbursed at 80 percent of the Medicare fee schedule.

Three aspects of the new fee schedule raise concern:

1. Reimbursement for the same service varies depending on the provider's specialty. For example, rheumatologists receive only 80 percent of the usual compensation for x-rays of the neck, thoracic, and lower spine. Otolaryngologists receive 80 percent of the usual payment for CP maxillofacial area exams and esophagrams with contrasts.

2. Under this new arrangement, the health plan is indirectly providing economic credentialing of physician competence.

3. Medica's new fee schedule could adversely affect the quality of health care by reducing the frequency with which important diagnostic procedures are performed in ambulatory settings. Physicians have noticed that while diagnostic imaging devices such as x-ray machines are being repaired, some patients refuse to go to hospitals or other facilities to receive diagnostic studies that would ordinarily be performed in the office.

Also, physicians were dismayed to learn in a recent Medica bulletin that due to the reduction of the 2 percent provider tax to 1.5 percent (effective January 1), Medica will adjust provider fee schedules "to account for the change." The MMA is troubled by such adjustments, noting numerous complaints from physicians who report that the pass-through mechanism does not allow them to receive the full amount of the provider tax from health plans.

MMA officers and staff have met with Medica leaders to discuss these issues and seek solutions that will best serve physicians and their patients.

Walgreens PDP

The MMA and the AMA have taken issue with aspects of Walgreens' participation in the Performance Drug Program (PDP). Walgreens implemented the PDP by sending a form letter to patients after their initial prescriptions had been filled.

The form letter, which suggested that an alternative drug therapy would be appropriate for the patients, could imply that the doctor was not considering the patient's best interest when prescribing medications. For instance, the letter states, "You may wonder why your physician did not select the most cost-effective product in the first place."

Dennis O'Dell, vice president of Walgreens, has informed the MMA that Walgreens is reviewing the PDP program and is considering modifications. • • • • •



Viewpoint

Kent S. Wilson, M.D.
President, Minnesota Medical Association

MMA's Vision for the 21st Century

I begin my term as president of the Minnesota Medical Association at a turning point for the MMA. After years of hard work, we have achieved major victories—repeal of the $400 surcharge, reduction of the 2 percent tax, and elimination of growth limits.

For six years, health system reform has driven the MMA agenda. Now we have come to the end of an era. Although there are still people in Minnesota who don't have health insurance and we haven't yet replaced the provider tax with a better alternative, we've come a long way.

Now it's time to look to the future. As we approach the 21st century, we face a tremendous challenge—to preserve the people's trust in our physician community.

We face ethical dilemmas. How do we deliver compassionate care to patients nearing the end of life? Debate about physician-assisted suicide and palliative care will continue.

We face economic pressures. How can we make sure that financial incentives encourage appropriate care—rather than pressure us to withhold care across the board? How do we keep our patients' trust that we are truly their advocates?

We face environmental threats. Are Minnesota's deformed frogs environmental sentinels? Are they the proverbial canaries in the coal mine?

We face threatening new diseases. How can we strengthen the link between public health and medicine to better cope with emerging diseases and resistant pathogens?

We face a crisis in medical education. How do we ensure that our training institutions are stable and that education is affordable for medical students and residents? We don't want to risk the possibility that young physicians—saddled with an enormous debt—might feel limited in their ability to act as their patients' advocates.

I'm confident that the MMA will rise to these challenges as it has done in the past. We have a history of success; we won antitrust relief, fairer Medicare reimbursement, and stronger antitobacco laws. We founded the Midwest Medical Insurance company and won awards for our "Stop the Violence" campaign.

As we face the challenges of the future, we must broaden the MMA's appeal to reflect the many changes in the practice of medicine. At the beginning of the century, physicians and patients made the medical decisions—a two-party system. The three-party system developed near mid-century when employers became the purchasers of health insurance. HMO legislation crystallized our current four-party system of patients, doctors, purchasers, and health plans.

This shift from the physician-patient model of care to a system that includes health plans and purchasers has brought changes in MMA membership as well. Many physicians are now employed by large health care organizations. We work in teams and organizations. Our financial incentives have changed. We are accountable for quality to more and more entities. Many of our members are women. Many are people of color. The MMA is challenged to reflect these new realities and to include everyone in the decision-making process.

Some principles never change. We will always value the doctor-patient relationship and strive to preserve its essential features. We intend to make sure that physicians and their patients are able to make medical decisions together and that the public continues to trust us.

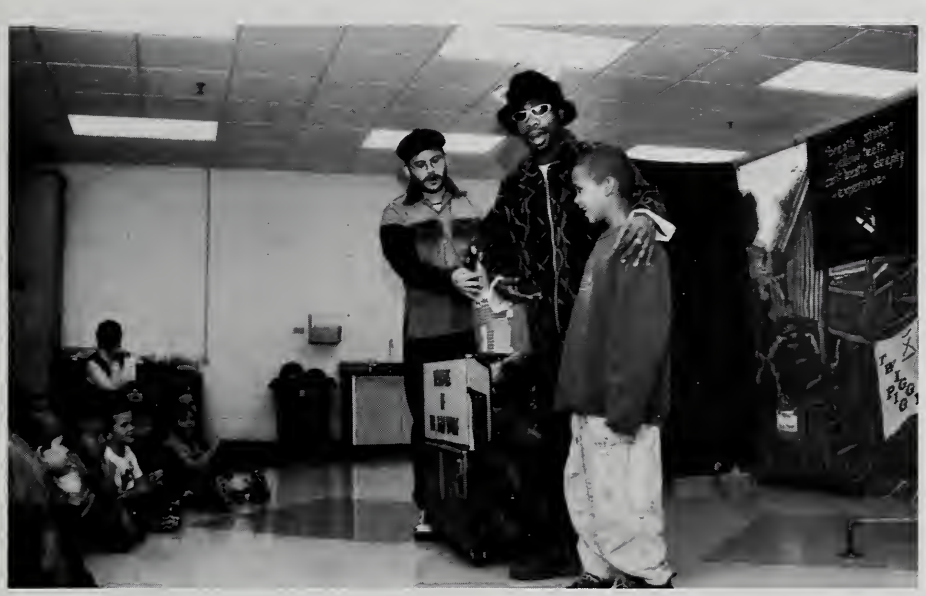
The MMA is the only organization whose sole purpose is to support the interests of all Minnesota physicians and their patients. But if the MMA is to continue to be a powerful force—one that's able to preserve the people's trust in the medical community—we must meet the changing needs of Minnesota physicians.

It's important to maintain and expand membership. To do that, we must identify discrete issues impacting small groups of physicians, as well as the issues that span all specialties and appeal to all physicians. How can we listen more carefully to our members and identify their varying concerns? Perhaps we should consider having physician groups or clinics represented in the House of Delegates and on the Board of Trustees. Traditionally, the MMA has been an organization of single individuals. Perhaps we should consider having clinics or groups represented as we do with students, residents, and specialties. The Strategic Planning Committee is considering these issues.

We are designing our plan for the 21st century. If we are to keep the people's trust, we must be ready to face ethical dilemmas, economic pressures, environmental threats, emerging diseases, the crisis in medical education, and more. ...

Working together, I know we can do it. • • • • •

'2 Smart 2 Smoke' Plays Educate Children About Tobacco



Foreground: Rocky the Pig of "2 Smart 2 Smoke" interviews South St. Paul's Moreland Elementary first-grader Andre Bradley for the position of Big Bad Wolf. The wolf who formerly held that title—now unemployed and grappling with a nasty chronic cough—stands in the background.

A Big Bad Wolf whose tobacco addiction has left him with a weak huff and puff, unable to blow in even the flimsiest straw house—whose stale, smoky odor renders him unfit even for a more low-key job in Little Red Riding Hood's story—is the subject of an innovative antismoking play by the National Theatre for Children.

"2 Smart 2 Smoke" is the first health-oriented production staged by the Minneapolis-based educational theater company (past plays have raised awareness on issues such as electrical safety and recycling). With a snappy yet informative script and accompanying curriculum packet developed by public health experts at the University of Minnesota, clever costumes and sets, and some extremely engaging young actors, the play is generating giggles, applause, and earnest discussions throughout Twin Cities-area elementary schools.

The National Theatre for Children is a 20-year-old professional touring company, founded and led by Ward Eames, which sells sponsorship of live, in-school, educational theater performances. Supplementary materials include teacher guides, in-class projects, and take-home workbooks. The company has demonstrated the lasting impact of its programs through pretests and posttests; Eames said scores typically increase by about 20 percent when posttests are administered (three months after a show).

Virtually every student who viewed one of the two recent performances at South St. Paul's Moreland Elementary appeared thoroughly captivated. Throughout the highly interactive plays, audience members—or, more accurately, participants—helped the three pigs audition a new Big Bad Wolf, helped educate the old one about smoking, and then offered him encouragement and support as he worked toward a decision to quit.

"Does smoking make you cool?" Rocky the Pig asked the sea of first- and second-graders at Moreland.

"NO!" was the thundering, unanimous reply.

A different "2 Smart" play, incorporating aliens and dark conspiracies, is being performed for grades 4 through 6. Its plot involves sinister tobacco company masterminds plotting to make millions by addicting the entire population of planet Tramsos to cigarettes. Luckily, the planet's residents don't fall for the scheme. As the play progresses, students deduce that Tramsos is "so smart" spelled backwards, and that the plot is a thinly veiled metaphor for the way cigarette makers target children and teens to create new customers.

The conclusion of both plays has actors and audience performing an infectious little clapping routine with the chant, "Too smart . . . to smoke!"

• • • • •

MMA, Smoke-Free 2000 Coalition Encourage Cosponsorship of '2 Smart'

• • • • • The MMA and the Smoke-Free 2000 Coalition invite component medical societies and clinics to join in a partnership to bring an innovative antismoking program, the National Theatre for Children's play "2 Smart 2 Smoke," to elementary school students in Greater Minnesota. Allina Health System is sponsoring performances in the Twin Cities metropolitan area.

Sponsors will help prevent children from starting to smoke and at the same time gain public recognition for their generosity. Posters, workbooks, and press materials are emblazoned with the names of sponsors in each community. The theater makes all scheduling and publicity arrangements.

To learn more about this exciting opportunity, please call Lorrie Holmgren at the MMA at 800/DIAL-MMA (800/342-5662) or 612/362-3748.

ANNOUNCEMENTS

Dickson, Smith to Serve on MMA Board of Trustees

Karen K. Dickson, M.D., a psychiatrist at Clinical Psychopharmacology Consultants, P.A., has been appointed to the MMA Board of Trustees to represent the West Metro Trustee District for a one-year term.

Henry T. Smith, M.D., chief of the Hennepin Faculty Associates Internal Medicine Division at Hennepin County Medical Center, has been appointed to the MMA Board of Trustees to represent the West Metro District for a three-year term.

MMA Board Elects Meiches, Dehen to Executive Committee

The MMA Board of Trustees in November elected James Dehen, M.D., a surgeon from the North Central Trustee District, and Robert Meiches, M.D., a geriatrician from the West Metro District, as members-at-large of the Executive Committee.

MMA Member Helps Lead New Patient Safety Group

An MMA physician will play a key role in the AMA's new National Patient Safety Foundation, which aims to create a safer health care environment by helping prevent accidental injuries and deaths.

Eric Knox, M.D., director of the Perinatal Center at Abbot Northwestern Hospital in Minneapolis, has been named chair of the foundation's Prevention and Implementation Committee, which will translate new knowledge into practical tools for providers to prevent injuries. Knox also is medical director of MMI Companies, based in Deerfield, Illinois.

The nonprofit National Patient Safety Foundation (NPSF) is an unprecedented effort to improve health care safety by studying why accidents occur in the health care system and implementing safeguards to prevent future accidents. According to a nationwide poll conducted by an independent survey research firm, more than 100 million Americans have been affected by what they consider a medical mistake, either in their own medical care or in that of a friend or relative.

Among specific ideas being discussed are the possible use of bar coding as a way to improve the tracking of medications delivered to hospital patients and expanding the use of simulators, or "smart dummies," in teaching crisis management skills. The NPSF also will explore parallels that may exist with other "high-risk" industries, such as aviation and nuclear power, and perhaps adapt successful safety interventions developed in those sectors.

Mary Ellen Otremba Elected to House in 11B

Mary Ellen Otremba, a schoolteacher from Long Prairie, was elected November 4 to the state House seat formerly held by her late husband. Rep. Ken Otremba, a dairy farmer and DFLer, was widely regarded as a champion of rural health care issues. He died of liver cancer in September. Mary Ellen Otremba, who was endorsed by MEDPAC—the political arm of the Minnesota Medical Association—defeated Republican Barb Schmitt of Staples.

MMA Past President Frank Johnson Dies

Frank E. Johnson, M.D., who served as president of the MMA in 1979–80, died October 25 at the age of 79. Johnson, a cardiovascular-thorasic surgeon, was the first surgeon in Minnesota to perform open-heart surgery in private practice. He served in the Navy during World War II as a lieutenant and physician on the *U.S.S. Occonto*. Johnson was instrumental in establishing the Children's Heart Fund, now known as Children's Heartlink, in Edina. Johnson is survived by his wife, Beryl M. Johnson, R.N., four children, and several grandchildren.

MMA Membership Renewal Campaign Underway

MMA members are receiving their renewal materials for 1998 memberships. The membership renewal packet includes a dues statement, MMA benefits and recent accomplishments, and information about the AMA. Renewal notices are being sent to member physicians in the Zumbro Valley, Range, and Lake Superior medical societies by those component societies.

Current MMA memberships expire December 31. All members are encouraged to renew their memberships early to avoid any lapses in benefits or services.

Members with questions about their statement or with changes to their employment status are encouraged to speak with a representative from the dues processing department. The MMA offers a variety of membership categories to reflect its diverse membership. The dues processing department can be reached at 612/378-1875 or 800/342-5662.

Physician Resource Guide: Support for Parents of Babies and Toddlers

How Important Are the First Three Years of Life?

- Whether a baby's genetic potential for intelligence is reached depends greatly on experiences in the first three years of life.
- Between birth and age 3—and especially in the first six months of life—a child's brain develops rapidly. Electrical activity of the brain cells—stimulated by sights, sounds, noises, touch, language, and eye contact—form synapses in the brain. These connections help determine the child's intelligence and ability to learn.
- Between 10 and 18 months, emotional and self-control connections are wired. The brain circuits that process sounds are wired by age 1. The brain circuits for math and logic are wired by age 4.
- Unless they are used, brain cells are eliminated. Connections that are never or seldom used wither and fade away. They can never be replaced. The window of opportunity for fully developing intelligence is open from age 0 to 3.

What Experiences Wire a Baby's Brain for Success?

- Research backs up a common-sense message delivered through history: It's important to hold, cuddle, and talk to a baby.
- Parents don't have to overwhelm babies with information or bombard them with activities. Stimulating a baby is as simple as playing peekaboo, shaking a rattle, singing a song.
- Babies whose moms, dads, or other caregivers read to them, talk to them, and play with them will be brighter, do better in school, and get along better with other people.
- Early attachment to the primary caregiver is a key factor in a baby's emotional and intellectual development.
- The number of words a baby hears each day helps determine language skills. TV and radio are no substitute. It's important for parents to make eye contact and talk directly to the baby.
- Babies who are abused learn to anticipate danger anxiously; their hearts race and their stress hormones surge when the smallest threat is perceived. These reactions set the stage for stress-related illnesses later in life.

How Can Physicians Help their Patients Raise Bright, Happy Kids?

- Prescribe parent education classes for all parents.
- Encourage parents to read and talk to their infants and toddlers.
- Provide information about parent support services.
- Put up posters, distribute brochures.
- Set up a Project Read story corner in your clinic: call Robert O. Fisch, M.D., at 612/624-7627 for more information.

Why Is Parent Education and Support Important?

Parenting is a tremendous challenge for people of any age, income, or education level. Babies don't come with instructions.

Parent education classes provide information about:

- Nutrition
- First aid, health, and wellness
- What to expect at various stages of development
- Language development
- Different ways to discipline effectively and nonviolently

Most parenting programs also provide encouragement and support.

What Parent Education and Support Programs Are Available?

- **Early Childhood Family Education (ECFE)**

  ECFE is a parent education, discussion, support, and play program in which parents participate with their children. ECFE is offered through local school districts to all Minnesota families with infants and children not yet enrolled in kindergarten. Community-

specific programs are offered in some districts. Fees are nominal and can be waived for families who are unable to pay.

Call 800/KIDS-709 or call your local school district.

- **Father's Resource Center**

  Parenting classes—along with counseling, housing, and financial and legal programs—are part of the Father's Resource Center's broader mission of providing men the "resources to be the kind of fathers their children need." The center can also refer dads to programs in greater Minnesota. Services are provided on a sliding fee scale.

  Call 612/874-1509.

- **MELD**

  MELD now offers group-based parenting education and support in 25 states. MELD's mission is to strengthen families in critical periods of transition. A variety of community-specific groups are offered, such as MELD for young moms, MELD for young dads, MELD for parents who have children with special needs, and MELD for Hmong parents. Programs are free.

  Call 612/332-7563.

- **Minnesota Parenting Association**

  Using the same model of peer-facilitated education and support, the Minnesota Parenting Association picks up where ECFE leaves off, working with families of school-age children.

  Call 612/290-4755.

- **Urban Ventures Center for Fathering**

  In both group-based and one-on-one settings, Urban Ventures teaches parenting skills, and helps fathers with "job skills, money skills, and life skills," toward the goal of fostering positive developmental outcomes for children. Referrals to other programs are also available.

  Call 612/822-0802.

- **Way to Grow** (Minneapolis only)

  Way to Grow, or WTG, supports parents and families in raising kids from newborns to age 6. WTG neighborhood sites offer classes, events, health and development information, referrals, and support. Services are free.

  Call 612/377-1012.

This list is by no means complete; it represents a small sampling of the many diverse education and support programs for parents in Minnesota. In many areas, faith communities and other organizations offer parenting classes and groups.

What Other Resources for Parents Are Available?

- **Child & Teen Checkups**

  Child & Teen Checkups is the name for the Minnesota Early Periodic Screening, Diagnosis and Treatment (EPSDT) program. All Medical Assistance (MA) enrolled children ages 0 to 21 should get regular Child & Teen Checkups. As long as a child is eligible for Medical Assistance, any follow-up diagnosis and treatment will be paid for by MA if medically necessary.

- **Family Nutrition Programs**

  To find out how to prepare healthy meals and make food dollars last longer, call the nearest Minnesota Extension Service office and ask for the Family Nutrition Program number in your area.

- **Family Support Network** (includes Parents Anonymous)

  This network of resources, which includes parent groups, children's programs, and referral services, exists to "promote positive parenting, healthy families, and homes where children are valued and loved."

  Call 612/523-0099 or 800/621-6322.

- **Greater Minneapolis Day Care Association**

  The association helps families find high quality, affordable, licensed day care providers.

  Call 612/341-1177 or 612/341-2066 for referrals outside of Minneapolis.

Helpful Web Sites

- *The Children, Youth and Family Consortium*
  www.cyfc.umn.edu
- *Parentsplace*
  www.parentsplace.com
- *The National Parenting Center*
  www.tnpc.com
- *Positive Parenting*
  www.positiveparenting.com
- *Parenthood Web*
  www.parenthoodweb.com
- *I Am Your Child*
  www.iamyourchild.org

- **Minnesota Children with Special Needs, Minnesota Department of Health**

  This state agency helps families of children with long-term handicapping physical disabilities obtain financial help and social services.

  Call 800/728-5420.

- **Parent Warmline**

  A service of Children's Health Care, the Parent Warmline offers support and advice, over the telephone, on developmental and behavioral issues for parents who are confused, frustrated, or stressed.

  Call 612/813-6336.

- **Resources for Child Caring (RCC)**

  RCC provides educational and nutrition services for child care providers, and child care fee reimbursement and referral services for parents. Clients receive help finding, assessing, choosing, and paying for quality child care.

  Call 612/641-0305 or 507/287-2497.

- **Women, Infants and Children (WIC)**

  WIC is a nutrition education program that provides supplemental foods to promote good health for pregnant, breastfeeding, and postpartum women, as well as for infants and children up to age 5.

  Call 800/WIC-4030.

What Brochures and Posters Are Available?

Many organizations offer positive parenting posters that physicians can display in their exam room or waiting area, brochures to be handed out to patients or included in prenatal packets, and other materials. A few are listed below.

- **Children's Health Care**

  Children's Health Care offers several positive parenting brochures and fact cards, on topics such as, "What Happens When You Shake a Baby Will Shake You," "Smart Discipline," and "How to Deal with Stress." Call 612/813-6222.

- **Info-U**

  The University of Minnesota Extension Service offers over 150 detailed, fact-based phone messages on parenting topics, ranging from "What to Do When Baby Cries" to "When Should You Call the Doctor?" To receive a brochure listing all of the message topics and their corresponding three-digit codes, dial 612/624-2200 or 800/525-8636 and enter 100; the voice prompt explains how to order a list. Physicians can also call their local county extension office; if the office does not participate in the program, they can call 612/704-2069. You can access printed versions of the messages at: www.extension.umn.edu

- **The Initiatives for Violence Free Families and Communities**

  This program offers colorful, eye-catching magnets and posters—in English, Spanish, and Hmong—that reinforce the following four principles:

- Never, never hit, spank, or slap your child. Never.
- Violence is learned; it can be unlearned.
- Parents are role models for teaching nonviolence.
- Being a parent is stressful. Use effective, appropriate, uncomplicated strategies to help bring you and your child to peace.

  To order magnets, call Nina Verin at 612/388-3902. For information about posters, call Mary Elizabeth Berglund at 612/266-2461.

- **MELD** offers a wide array of handouts and posters. Brochures range from child development handouts to "Parent/Child Activities" and "Toys and Games for Babies." Posters promoting MELD programs, perfect for displaying in patient reception areas, include "Dads have babies, too" and "Does it mean he's hot, cold, tired, thirsty, or just in need of a hug?" Also available are illustrated charts describing age ranges for developing skills and behaviors during infancy and childhood. Call MELD at 612/332-7563 to request a catalog and order form.

- The **MMA** has created bright yellow prescription pads emblazoned in royal blue type with the heading "Rx for a Healthy Baby," encouraging parent education classes and listing phone numbers for ECFE and MELD. Call the Minnesota Medical Association at 612/378-1875 or 800/342-5662 and ask for Beth Hoheisel.

- **United Way's Success by 6** program offers a collection of colorful "tip cards" on subjects such as "Tips for a Safer Childhood" and "Learning to Relax." The front of each card explores a different issue, and the back provides names and phone numbers of agencies and organizations that can help parents with that issue. To find out what other tip cards are available, or to place an order, leave a message at 612/340-7437 and your call will be returned.

Hepatitis C Coalition Begins Groundbreaking Campaign

The MMA was one of over 30 organizations to help kick off a pioneering hepatitis C public education campaign on November 7. MMA staff were among a diverse crowd of Hepatitis C Coalition members at a press conference unveiling a statewide effort to heighten awareness of, and expand testing for, the hard-to-detect disease.

According to state epidemiologist Michael Osterholm, Ph.D., up to 40,000 Minnesotans may have hepatitis C—a potentially fatal liver disease—and not even know it. Hepatitis C is transmitted primarily through contaminated blood.

Individuals considered at risk include: people who shared needles to inject IV drugs, people who had tissue or organ transplants before 1992, people who had blood transfusions before 1992, people who are or have been on hemodialysis, people who have had unprotected sex with multiple partners, and physicians, nurses, paramedics, or other health care professionals who were inadvertently stuck with a needle from a patient infected with hepatitis C.

When testing of blood donations began in the early 1990s, blood tainted with hepatitis C was screened out. The FDA has debated for months about whether—or how—to notify potential victims who may have received blood from infected donors before screening began. Officials from the Hepatitis Foundation International, a New Jersey-based advocacy and education group, praised the Minnesota coalition for taking a leadership role.

Osterholm urges patients who fall into the risk categories to ask their physicians for a hepatitis C test. Usually the disease does not become apparent until significant liver damage has occurred. If hepatitis C is caught early enough through testing, the immune-boosting drug interferon can help control or reverse it. Another goal of the campaign is to get out the message that alcohol consumption can exacerbate the disease's progression toward cirrhosis or liver cancer, so those who are infected can avoid drinking if they choose.

Some of the dozens of other Hepatitis C Coalition members include the state Department of Health and the Department of Human Services, the Minneapolis and St. Paul chapters of the Urban League, the Center for Cross-Cultural Health, and the Indian Health Board. The risk of infection is higher in some communities of color, so the coalition plans to produce ads and brochures in Spanish and Southeast Asian languages. African American, Native American, Asian American, and Latino media are playing prominent roles in the coalition's endeavors.

The coalition offers a brochure that provides general information about hepatitis C; to obtain free copies, for display in exam rooms or patient waiting areas, call Mark Schiffman at 612/831-3200. • • • • •

HTAC Will Evaluate Thrombolytic Therapy

Due in part to an MMA recommendation, the Health Technology Advisory Committee (HTAC) approved formation of a work group to study the use of thrombolytic therapy—specifically tissue plasminogen activator (t-PA)—in the treatment of ischemic stroke. The MMA passed a resolution at the Annual Meeting in September calling for various measures to fight ischemic stroke; among the recommendations was that HTAC plan and implement strategies for promoting effective stroke management. MMA members who are interested in participating in discussions of t-PA or who would like to be kept informed of the work group's activities should call Mary Stadick of HTAC at 612/282-6355. • • • • •

Oregon Keeps Death With Dignity Act

Oregonians voted to keep the assisted-suicide law—days after the U.S. Supreme Court rejected the final appeals of opponents who had blocked it from taking effect—they first approved in a 1994 referendum. Oregon is the only state to expressly allow physician-assisted suicide.

Although the Oregon Medical Association supported the ballot measure to overturn the law, it announced its intention to comply with voters' wishes. "The fact is that the law is the law, and obviously we as an organization respect what the voters have done, and we are going to have to live with the law. That's the way of democracy," said Jim Kronenberg, OMA associate executive director.

Under the law, a mentally competent adult suffering from a terminal illness—defined as likely to result in death within six months—may receive two lethal doses of medication after consulting with two physicians and waiting 15 days. Included are provisions meant to ensure that the patient's decision is voluntary and not the result of depression. • • • • •

The Monitor
DECEMBER 1997
• • •
PRESIDENT
Kent S. Wilson, M.D.

CHAIR, BOARD OF TRUSTEES
Paul C. Matson, M.D.

CHIEF EXECUTIVE OFFICER
Paul S. Sanders, M.D.

EDITOR
Lorrie Holmgren

WRITER
Susan Maas
• • •

UNIVERSAL COVERAGE

continued from page 32

17 percent of kids.[7] In fiscal year 1993, an average of 387,763 Minnesotans were eligible for Medicaid each month: half of these were children under age 18.[8]

Health Insurance Reform: Expanding Options

Minnesota Comprehensive Health Association

Minnesota was the first state to create a high-risk insurance pool for persons who are uninsured because they have or have had a medical condition and have been denied coverage due to a pre-existing condition exclusion. The Minnesota Comprehensive Health Association (MCHA) was created as part of the Minnesota Comprehensive Health Insurance Act of 1976 to provide an alternative source of health coverage for people who are unable to obtain health insurance in the private market and who do not qualify for public assistance such as Medicaid. The MCHA population includes persons with chronic or high-risk conditions such as diabetes, cancer, AIDS, and heart disease. Many people needing this insurance are either self-employed or work for small firms whose group plan won't cover pre-existing conditions. To obtain MCHA coverage, an applicant must be a Minnesota resident unable to obtain coverage in the private sector, as evidenced by a rejection notice from an insurer.

Currently, MCHA is required to offer two comprehensive medical plans with different deductibles and a qualified Medicare supplement plan. The premium for these plans can be no more than 125 percent of the weighted average rates charged by insurers and HMOs selling comparable individual policies. The program is funded by enrollee premiums and by assessments on HMOs and private insurers (self-insured plans are excluded because of the Employee Retirement Income Security Act). As of April 1995, MCHA had approximately 30,000 enrollees statewide. The vast majority of enrollees are between 45 and 64 years old. However, a number of vulnerable, "high-risk" children currently receive health benefits through the MCHA program.

Children's Health Insurance Reform Plan

Many children are covered by a parent's insurance plan that does not cover preventive and primary care services. The American Academy of Pediatrics has attempted both at a national and state level to address this issue through an insurance reform proposal that has come to be called the Children's Health Insurance Reform Plan (CHIRP). In 1988 Minnesota became the first state to enact this legislation. The components of the plan mandate coverage of comprehensive prenatal, preventive, and health supervision services, including immunizations. Cost sharing, either deductibles or copayments, cannot be charged for these services. The program was created to provide coverage to families and children with high out-of-pocket expenses due to limits in insurance coverage for basic child health services.[9] The program was conceived because as many as 58 percent of preschool children had not received the preventive care recommended by the American Academy of Pediatrics and the U.S. Public Health Service.[10]

Medicaid Waivered Programs: Integrating Systems and Broadening Services

States have had the option since Medicaid's inception to request waivers of various federal provisions, including those requiring consistency of the program across the state, freedom of choice, and identical benefit sets throughout the state. Since the Omnibus Budget Reconciliation Act was passed in 1981 (OBRA '81), states have used Medicaid waivers, demonstration and programmatic, to institute Medicaid policy changes and to transform how services are provided to eligible recipients. As discussed earlier, Minnesota has used waivers to expand coverage for pregnant women and children.

Transition to managed care

Managed care for Medicaid recipients in Minnesota began in 1982, when Minnesota became one of five states to obtain a waiver from the Health Care Financing Administration (HCFA) to test innovations in health care financing and delivery under demonstration projects authorized by Section 1115 of the Social Security Act. Minnesota's model was a capitated prepaid health plan for the Medicaid population to be tested in one rural, one suburban, and one urban county. HCFA and the Minnesota Legislature approved the design in 1983. The purpose of the waiver was to gain more flexibility in service delivery and to realize financial savings largely through managed care.

Implementation began in 1985, and although the program was to be a three-year demonstration, congressional action extended Minnesota's project through June 1996 and allowed for expansion to other counties. As the initiative moved from a demonstration project to a permanent approach to health care delivery, managed care for Medicaid clients became known as the Prepaid Medical Assistance Program, or PMAP. As of November 1997, 26 counties were participating in the PMAP program.

However, the state has met with substantial opposition as it works to convert additional counties and groups of recipients to managed care Medicaid. Health plan administrators and providers fear that reimbursement rates under managed care will be even lower than the rates under the fee-for-service system. Advocates of beneficiaries believe that managed care will limit the choice of providers, particularly providers with experience caring for the poor and those with special needs. Finally, rural counties voice concerns that health plans will not work collaboratively with community health service agencies and that the Department of Human Services has failed to consult on the special access needs of rural Minnesota.

The Balanced Budget Act & KidCare

By Janet Silversmith

The Balanced Budget Act President Clinton signed in August included one of the federal government's most significant efforts to expand health care coverage since the adoption of Medicare and Medicaid in 1965. The legislation calls for the establishment of the State Children's Health Insurance Program (CHIP) as Title XXI of the Social Security Act. The program, often referred to as KidCare, was sponsored by Sen. Orrin Hatch and Sen. Edward Kennedy.

The program was created to address the large and growing number of uninsured children in the United States, currently estimated at 10 million. It gives states flexibility to initiate and expand health insurance coverage for low-income, uninsured children. The target population for Title XXI is children under age 19 whose family income is below 200 percent of the federal poverty guideline (FPG) or no more than 50 percentage points above the current Medicaid coverage level (325 percent in Minnesota).

Congress appropriated approximately $40 billion over the next 10 years for the program. About $4.2 billion is available to states for federal fiscal year (FFY) 1998 (October 1, 1997, through September 30, 1998). To access the money, a state must submit for approval to the Health Care Financing Administration a detailed plan describing how it intends to implement the program. States must have an approved plan in place before October 1998 in order to access the FFY 1998 funds. The dollars allotted for a given year can be carried over for three years, giving states time to develop their plans before they have to use the money. Based on the law's allocation formula, Minnesota, with an estimated 50,000 qualifying children, has been allocated $28.4 million for FFY 1998.

Funding for CHIP, like Medicaid, depends on state expenditures, which are matched by federal dollars. The federal share Minnesota receives for Medicaid is 52 percent; the federal match for the CHIP program is 66.5 percent.

While granting states some flexibility in implementing the new program, the federal government has limited the use of the funding to cover four options: 1) the cost of health insurance for children under a new program; 2) the cost of expanding Medicaid for additional children; 3) direct reimbursement to providers for serving children; and 4) outreach activities and administrative costs.

The first option, providing for health coverage under a new program, requires that the benefits provided be comparable to benefits offered to federal or state employees. States that implement a new program are subject to cost sharing and benefit rules and must coordinate enrollment in the program with Medicaid enrollment.

The second option allows states to expand Medicaid to serve additional children. Expansion would apply to children who do not qualify for Medicaid under state criteria in effect as of April 14, 1997. In Minnesota, pregnant women and children at up to 275 percent of the FPG currently receive Medicaid coverage. Consequently, Minnesota can only expand Medicaid to include children between 275 percent and 325 percent of the FPG. Opponents to expanding Medicaid to this income group fear that private coverage will be reduced in favor of state-subsidized coverage.

The Balanced Budget Act contained three changes to the Medicaid program designed to increase a state's ability to provide coverage to children. Presumptive eligibility allows states to enroll children temporarily in the Medicaid program based on income information provided by particular entities. Another provision requires states to continue Medicaid coverage for all disabled children who were receiving supplemental security income on August 22, 1996, but who lost their Medicaid eligibility after last year's welfare reform law. Finally, states now have the option to guarantee 12 months' continuous coverage to children enrolled in Medicaid.

The third and fourth options for using the Title XXI funds—direct reimbursement and outreach and administrative costs—are limited to 10 percent of total expenditures under the new program.

The State Children's Health Insurance Program offers states the ability and the resources to provide meaningful health insurance coverage for children. The approach Minnesota will take is unclear. The state has dramatically reduced the number of uninsured residents, both children and adults, through the MinnesotaCare program, established in 1992.

During the next legislative session, Minnesota must decide whether and how to design a CHIP program. The state will likely attempt to modify provisions of MinnesotaCare to gain access to the federal dollars. Counterproposals for private-section initiatives are also expected. Whatever the focus, the opportunity to design a program that further protects low-income, uninsured children should not be missed.

Janet Silversmith is a health policy analyst with the Minnesota Medical Association.

Conversely, proponents of managed care believe that access to providers increases under a managed care system because providers who contract with a health plan cannot refuse to serve Medicaid enrollees. Proponents also have suggested that health plans will want to ensure adequate, preventive care to keep overall costs low, and therefore, clients will receive better service. This controversy is not unique to Minnesota, but nonetheless has made the expansion of managed care for Medicaid patients political and emotional.

Home-based and community-based waivers

In response to the expanding role of Medicaid in financing long-term care and the demands of special-needs populations, the federal government provided for home- and community-based services waivers known as 1915(c) waivers.[11] In 1993, expenditures for long-term care services (i.e., home health, care for the mentally retarded, and nursing facilities) accounted for nearly 40 percent of total Medicaid expenditures; however, more than 85 percent of all long-term care expenditures were for institutionally based care.[12] Therefore, directing expenditures toward noninstitutionalized care would likely save money and improve quality of life.

The 1915(c) waivers allow federal Medicaid reimbursement for services not usually covered by the program. The services that may be funded include case management, homemaker services, home health aides, personal care services, adult day health services, habilitation, and respite care. Four eligibility groups may be targeted for these waivered services—the aged, mentally retarded/developmentally disabled, disabled under 65 years old, and those who would otherwise be inappropriately placed in a skilled or intermediate nursing facility. As of August 1995, more than 13,000 Minnesotans were served under these waivers. The program is particularly beneficial to a small number of children who are technology-dependent and receive home-based care through provisions of the waivered program.

A similar program for special-needs children who benefit from home-based services is the Tax Equity and Fiscal Responsibility Act (TEFRA) of 1982. Though not a waivered program, it is a Medicaid provision for children with significant disabilities whose parents' income is above the Medicaid threshold for the state. Minnesota has used this option for children since 1988. During fiscal year 1994, 3,534 children used $23.6 million in Medicaid benefits under TEFRA in Minnesota.

Health care reform waiver

In 1993, under direction from the Legislature, the Minnesota Department of Human Services developed a plan to integrate the financing and delivery of Medicaid, GAMC, and MinnesotaCare. The multiple and varied eligibility requirements for these programs make it extremely confusing for clients, providers, and administrators. The state wanted to create a seamless system that would cut down on paperwork (and administrative costs) and lead to better continuity of care. The state also sought to gain federal financial participation for its MinnesotaCare and GAMC programs, which are funded solely by the state. In 1994, the state submitted a waiver request to HCFA to allow for such a system, and in April 1995 received approval for a modified plan. As the state moves to managed care for all publicly funded care, the health care reform waiver is expected to provide the vehicle for such a seamless system.

Discussion

Minnesota has made significant strides toward ensuring that every child in the state has access to health insurance coverage. The approach has been slow and incremental. After 20 years of conceptualization, planning, and health care reform legislation, we have insured about 97 percent of the state's children.

Sustaining energy, interest, and consistent direction among policymakers, advocates, and other stakeholders has been a challenge. Financial access to coverage is imperative; however, it does not guarantee appropriate utilization. Geographic and cultural barriers can prevent people, particularly the poor, from obtaining needed health care.

In Minnesota, managed care organizations have struggled to improve utilization of needed services. Health plan studies after enrolling Medicaid patients found that barriers to access beyond finances included lack of transportation, child care, and interpreter services.[13] Another recent study found additional barriers to receiving adequate prenatal care, including psychosocial, structural, and sociodemographic factors.[14] Since these findings, local health plans have begun to provide services such as bus tokens or cab fare, child care in clinics, and translators at their customer service offices and at clinics and hospitals.

Minnesota's multifaceted approach has included legislation, regulations, federal waivers, managed care strategies, and community adaptation. Although this approach has caused some fragmentation and confusion, it has also resulted in fewer uninsured Minnesotans than the U.S. average, close to universal coverage for children, and better coordination of care. The recently enacted State Children's Health Insurance Program provides yet another opportunity for Minnesota and other states to further improve health care coverage for children. See the sidebar, page 42, for a summary of the program and its possible impact in Minnesota. MM

Charles Oberg is an associate professor of pediatrics at the University of Minnesota Medical School, senior vice president of medical affairs of Hennepin Faculty Associates, and interim chief of the Department of Pediatrics, Hennepin County Medical Center. He was one of the original members of the Minnesota Health Care Access Commission, which crafted the first MinnesotaCare proposal. Deborah Chase is director of policy for government programs at Allina. When she wrote this article, she was director of Hennepin County's Health Policy Center.

continued

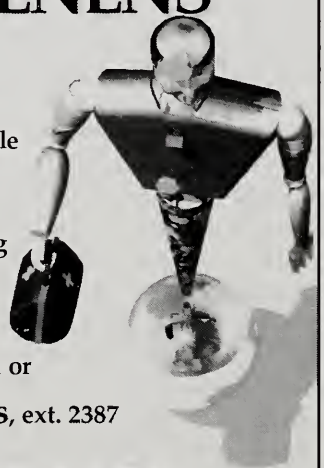
Park Nicollet Clinic
HealthSystem Minnesota

OBSTETRICS AND GYNECOLOGY

Minneapolis: BC/BE Obstetricians/ Gynecologists needed to join the 28-person Department of Obstetrics and Gynecology of a 422-physician multispecialty clinic in the desirable Twin Cities area. We have positions available at our Bloomington, Brookdale, Burnsville, Carlson Center, and Shakopee offices. Comprehensive salary and benefit program. For additional information contact Patrick Moylan at 612/993-5986 or send CV and letters of inquiry to Mr. Moylan, Professional Practice Resources, Park Nicollet Clinic, HealthSystem Minnesota, 3800 Park Nicollet Blvd., St. Louis Park, MN 55416; or fax 612/993-2819.

Staff Care, Inc.
"The nation's fastest growing locum tenens firm"

YOUR BEST MOVE FOR LOCUM TENENS



- Nationwide opportunities
- Government settings available
- Occurrence malpractice
- Paid travel, licensure, lodging

Ask for :
John Moberly, ext. 2381 or
Melanie McReynolds, ext. 2387

(800) 685-2272
http://www.locumsnet.com

Staff Care is proud to sponsor the Country Doctor of the Year Award

Unable to place J-1 or H-1 physicians

REFERENCES

1. Call KT, Lurie N, Jonk Y, Feldman R, Finch MD. Who is still uninsured in Minnesota? lessons from state reform efforts. JAMA 1997;278(14):1191-5.
2. Kennell DL, Sheils JF. Analysis of health insurance coverage and health care utilization and expenditures in Minnesota. Washington, D.C.: ICF Inc., 1985 [prepared for the Minnesota State Planning Agency].
3. Lurie N, Orbovich CB, Klein JD, Miles SH, Oberg CN, Dowd BE, Finch MD, Quam L. From data to policy to politics: the Minnesotan's health care plan for universal access to care. Arch Intern Med 1992;152:2222-8.
4. Minn. Stat. § 620.165, subd. 1.2.
5. The Kaiser Commission on the future of Medicaid. Washington, D.C.: The Kaiser Foundation, 1993.
6. Erdman K, Wolfe SM. Poor health care for poor Americans: a ranking of state Medicaid programs. Washington, D.C.: Public Citizens Health Research Group, 1988.
7. Loprest P, Gates M. State-level data book on health care access and financing. Washington, D.C.: The Urban Institute, 1993.
8. Minnesota welfare: a guide to public assistance programs in Minnesota. St. Paul: Minnesota House of Representatives Research Department, January 1995.
9. Child Health Insurance Reform Plan (CHIRP). State legislative packet, state government. Elk River, Illinois: American Academy of Pediatrics, 1993.
10. Short PF, Lefkowsitz DC. Encouraging preventive services for low-income children: the effects of expanding Medicaid. Medical Care 1992;30(9):766-80.
11. Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35, § 2176 (1981).
12. Health Care Financing Administration. Medicare and Medicaid statistical supplement. Health Care Financing Review 1995;16(suppl.):118-55.
13. Medicaid managed care study: summary of results. Minneapolis: Medica Foundation, 1993.
14. Lia-Hoagberg B, Rode P, Skovholt CJ, Oberg CN, Berg C, Mullett S, Choi T. Barriers and motivators to prenatal care among low-income women. Social Sciences and Medicine 1990;30(4):487-95.

The Incidence of Child Suicide in Minnesota

Jon Roesler, M.S.

ABSTRACT

BACKGROUND: Although child suicide is a relatively rare occurrence, it is a growing problem that warrants additional attention both in Minnesota and nationally.

METHODOLOGY: We obtained mechanisms-of-death data coded from death certificates of Minnesota residents under age 15 who had committed suicide during the five-year period 1990 to 1994. In addition, we calculated three-year floating average annual rates for the years 1975 to 1993.

RESULTS: A total of 37 children aged 5 to 14 committed suicide from 1990 to 1994, an annual rate of 1.1/100,000. In most cases, the child used a firearm. Three-year floating annual rates ranged from a low of 0.4/100,000 in the years 1980 and 1981, to a high of 1.4/100,000 in 1992 and 1993.

DISCUSSION: Because child suicide is an infrequent event, little research has been done on prevention strategies. Our results suggest child suicide is increasing, and consequently, new prevention strategies should be explored.

Child suicide is a relatively rare occurrence, but with an intensely distressing impact on parents, siblings, and friends. In the United States, the rate of suicide among children aged 5 to 14 has increased twofold since 1968, and suicide is now the sixth leading cause of death in this age group.[1] The largest increase in the rate of suicide among all age groups has been in children 10 to 14 years of age.[2] In Minnesota, public concern about suicide in this population was demonstrated by front-page articles in Minnesota's two largest daily newspapers after an 11-year-old boy attempted suicide.[3,4]

About 1 million children under age 15 live in Minnesota. Although the overall rate of suicide in Minnesota is lower than the U.S. rate,[5] for youth aged 10 to 24 the suicide rate is significantly greater. Minnesota's rate, 11th highest in the nation, increased 38% from 1979 to 1988.[6] The absolute numbers are small, but numbers fail to tell us about the growing problem and its causes. An epidemiologic analysis is the first step to understanding.

Methodology

We obtained mechanisms-of-death data (ICD-9 E-codes[7]) from the Minnesota Center for Health Statistics for the five-year period 1990 to 1994. Decedents included in this analysis were Minnesota residents under age 15 with cause-of-death codes E950-E959. In addition, we ascertained the number of suicides and the estimated population of children aged 5 to 14 years from the Minnesota Center for Health Statistics annual reports from 1974 to 1994.[8] Because child suicide is an infrequent event resulting in wide year-to-year variation in the annual rates, we calculated three-year floating average annual rates for the years 1975 to 1993.

Results

A total of 37 Minnesota children 5 to 14 years of age committed suicide from 1990 to 1994 (see the table). The number of suicides each year ranged from one to 16. A firearm was used in more than half of these suicides. Two of the suicides occurred in children aged 5 to 9. Both of those were committed by boys in 1992. The average annual rate of child suicide for children over age 5 was 1.1/100,000.

The three-year floating annual rates ranged from a low of 0.4/100,000 in the years 1980 and 1981, to a high of 1.4/100,000 in 1992 and 1993. Plotting the three-year floating averages reveals a generally increasing trend since 1980, as shown in the figure.

Discussion

The average three-year rates in 1980 (0.4/100,000) and 1990 (0.7/100,000) for Minnesota are the same as those reported for the United States.[1] This is somewhat misleading since both 1980 and 1990 represent brief valleys in what appears to be an increasing trend in Minnesota. The five-year average rate for 1990 to 1994 of 1.1/100,000 is more than 50% higher than the three-year average rate for 1990. Nonetheless, the infrequency and year-to-year variability of the number of child suicides in Minnesota makes ascertaining a trend tenuous at best.

Underreporting of child suicide is a significant problem; as many as one-half to two-thirds of suicides go unreported. This may be intentional or unintentional. Doctors, family, and friends may intentionally cover up a suicide for various reasons: guilt, social stigma, potential loss of insur-

ance, etc. Or suicides may unintentionally be mislabeled "accidents" if the cause of death is unverifiable—if there is no note or other evidence. Furthermore, it may be much easier to cover up suicide in children, as the suicide would be more easily perceived as an unintended death.[9]

Prevention of childhood suicide involves more than a single strategy because it is a complex behavior that involves affect regulation, early developmental experiences, constitutional factors, ego functioning, and interpersonal relations. Physicians and other professionals detect and treat depressive disorders, a typical approach to child suicide prevention. However, suicidal behavior is influenced more by the degree of hopelessness than by the degree of depression. Furthermore, not all children who are suicidal are depressed.[10]

The leading public health strategy for preventing childhood suicide (as well as unintentional childhood deaths) calls for reducing the availability of lethal agents.[11,12] Since most child suicides are committed with a firearm, limiting access to firearms is especially important. All gun owners need to safely secure firearms, especially when stored in an area where a child might gain access. Firearms should be unloaded and locked. Usually, firearms can be further secured with a trigger lock, available for under $10 from various retailers. Ammunition should be safely secured separately from the firearm. Minnesota Statute 609.666 actually makes it a crime to store a loaded firearm in a location where a person under age 18 is likely to gain access. (The Minnesota Medical Association's brochure "Unload It & Lock It" describes safe and responsible firearm ownership.*)

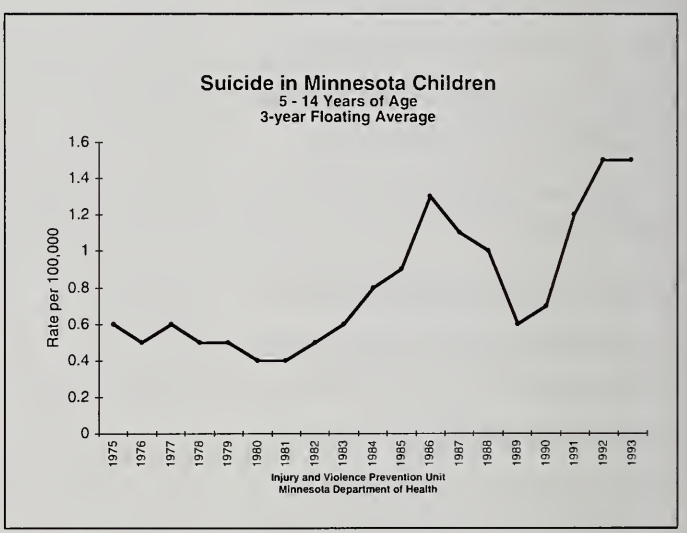
Public health nurses are important players in limiting children's access to lethal agents. The Injury and Violence Prevention Unit at the Minnesota Department of Health has developed the nationally recognized Home Safety Checklist for use by public health nurses when doing home visits. The checklist includes an in-home assessment of the storage of firearms, medicines, and cleaning supplies. Use of this checklist, along with education and immediate, no-cost provision of a simple and inexpensive cabinet, drawer, and gun trigger lock can make the home a safer environment and reduce the risk of child suicide.†

Table

*Suicide in Minnesota children 5 to 14 years of age**

Year	1990	1991	1992	1993	1994	Total
Total	1	6	16	9	5	37
Gender						
Male	1	5	13	7	2	28
Female		1	3	2	3	9
Method						
Firearm		4	8	4	3	19
Hanging/suffocation	1	2	4	3	2	12
Poisoning—solid/liquid			2	1		3
Poisoning—gas/vapor			2			2
Unclassified				1		1

* Injury and Violence Prevention, Minnesota Department of Health



FIGURE

The media also have multiple roles in suicide prevention. Beyond educating and providing information to the public, the media must be careful not to sensationalize suicides and suicide attempts. One risk factor for suicides is suicide "contagion," a process by which news coverage of suicide influences others to attempt the same. This effect is strongest among adolescents. Although studies of child suicide have not yet examined this issue, one might expect children also to be susceptible to imitative suicide.[11] Suicide or attempted suicide by a child may be newsworthy, but the media must report this tragic event responsibly. Media reports should be concise and factual and should avoid glorifying the victim and details about the methods used. Because a front-page article by a newspaper or a lead story on a television newscast increases the risk of contagion, the Centers for Disease Control and Prevention has issued guidelines for appropriately reporting a suicide.[13]

Conclusion

Self-destructiveness among children presents us with a paradox. Children

* To order brochures for your office, call Beth Hoheisel at 612/378-1875.

† The Home Safety Checklist is available in English, Native American, Spanish, and Hmong formats. Call Laurel Briske, R.N., P.N.P., at the Minnesota Department of Health, 612/623-5682.

have lower rates of suicide than do older age groups, implying some protective factor. However, perhaps because of the overwhelming tragedy of each event, suicide in children seems to attract more public attention than other suicides. Child suicide is an infrequent event and little research and evaluation has been done on prevention strategies. Because the incidence of childhood suicide is increasing, we urgently need to explore new prevention strategies. MM

ACKNOWLEDGMENT

The author wishes to thank Norbert Hirschhorn, M.D., M.P.H., Laura Hutton, M.A., Mark Kinde, M.P.H., and David Stroud, M.B.A., at the Minnesota Department of Health for their support, help, and comments. This paper was funded by the Minnesota Traumatic Brain and Spinal Cord Injury Program at the Minnesota Department of Health.

Jon Roesler is senior epidemiologist of injury and violence prevention at the Minnesota Department of Health.

REFERENCES

1. Singh GK, Yu SM. U.S. childhood mortality, 1950 through 1993: trends and socioeconomic differentials. Am J Public Health 1996;86:505-12.
2. Suicide among children, adolescents, and young adults—United States, 1980-1992. MMWR 1995;44:289-91.
3. Boy shoots himself at school. Star Tribune 1996 September 24;Sect. A:1.
4. Suzakamo L. Pre-teen suicides prove rare, but impulses common. Saint Paul Pioneer Press 1996 September 26;Sect. A:1.
5. Devine OJ, Annest JL, Kirk ML, Homgreen P, Emrich SS. Injury mortality atlas of the United States, 1979-1987. Atlanta: Centers for Disease Control and Prevention, 1992.
6. Warren CW, Harris WA, Kann L. Mortality trends, causes of death, and related risk behaviors among U.S. adolescents. Atlanta: Centers for Disease Control and Prevention, 1993.
7. Manual of the international classification of diseases, injuries, and causes of death, ninth revision. Geneva, Switzerland: World Health Organization, 1977.
8. Minnesota health statistics. Minneapolis: Minnesota Department of Health, 1974-1995.
9. Holinger PC, Offer D. Sociodemographic, epidemiologic, and individual attributes. In: Davidson L, Linnoila M, eds. Report of the Secretary's Task Force on Youth Suicide, volume 2: risk factors for youth suicide. Washington, D.C.: U.S. Government Printing Office, 1989.
10. Pfeffer C. The suicidal child. New York: Guilford Press, 1986.
11. Wilson MH, Baker SP, Teret SP, Shock S, Garbarino J. Saving children: a guide to injury prevention. New York: Oxford University Press, 1991.
12. National Committee for Injury Prevention and Control. Injury prevention: meeting the challange. Am J Prev Med 1989;5(3)(Suppl).
13. O'Carroll PW, Potter LB. Suicide contagion and the reporting of suicide: recommendations from a national workshop. MMWR 1994;43(RR-6):9-18.

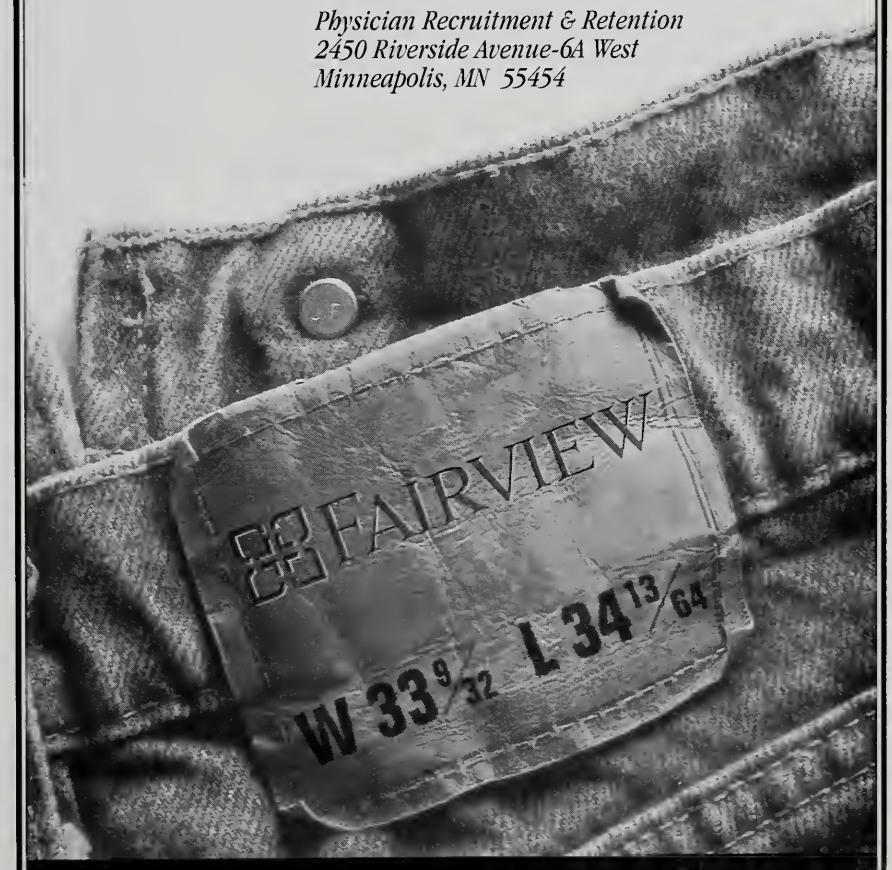
The perfect fit...

...is a rare find. Fairview Health Services represents a wide spectrum of practice and lifestyle options in Minnesota. We will help you locate opportunities that are tailored to fit your needs in communities large, medium and small (and sizes in between) for...

- **Family Practice**
- **General Surgery**
- **Internal Medicine**
- **Obstetrics/Gynecology**
- **Occupational Medicine**
- **Ophthalmology**
- **Orthopedic Surgery**
- **Physical Medicine/ Rehabilitation**
- **Urgent Care**
- **Urology**

FAIRVIEW

Physician Recruitment & Retention
2450 Riverside Avenue-6A West
Minneapolis, MN 55454



(800)842•6469 or (612)672•2288
E-mail: dgustaf1@fairview.org

Routine Screening During Pregnancy

The New Minnesota Pregnancy Risk Assessment Form

Thanks to a collaborative statewide effort, a standard pregnancy risk-assessment form is now available for Minnesota practitioners.

Pamela Weiss, Ph.D., R.N., and Peter M. Mark, M.D.

Editor's Note: Risk screening has become routine care for pregnant women. Obstetricians and family physicians are often faced with several different forms, each required by a different health plan or provider group to assess risk for a number of adverse outcomes, from preterm birth to gestational diabetes. After several years of diligent efforts to define the essential elements of risk assessment, we now have a standardized prenatal risk-assessment form that is accepted by all the major health plans and insurers in Minnesota. This is a boon to Minnesota women and their physicians. This type of collaborative effort benefits physicians, women, and even insurers. I hope you will incorporate this form into your prenatal practice.

–Barbara P. Yawn, M.D., M.Sc.,
Series Editor

The Minnesota Pregnancy Assessment Form, the new standard risk-assessment tool for pregnant women in Minnesota, was disseminated in March 1997. This form is the result of a collaborative process initiated by the Minnesota Council of Health Plans, the Minnesota Department of Human Services, the Minnesota Department of Health, the Minnesota Medical Association, and community experts. The goal was to create a practical, easy-to-implement, single form for statewide use.

The new form is based on an extensive review of the literature and committee members' clinical experience. The committee included health plan representatives; representatives of the Minnesota Nurses Association, the Minnesota Obstetrical and Gynecological Society, and the Minnesota Academy of Family Physicians; practicing physicians, nurses, and nurse midwives; and staff of the Minnesota departments of health and human services. The form includes only risks for conditions that respond to medical intervention or that merit monitoring. For instance, it includes risks related to preterm births and low birthweight, as well as other poor pregnancy outcomes.

Literature Review

Risk assessment is essential in the care of pregnant women, a philosophy that is well-stated in the Fairview Physician Associates' "Clinical Pathways Guidelines Preterm Birth Prevention Manual":

"Early recognition and treatment are keys to decreasing preterm birth and poor pregnancy outcome and its associated morbidity and mortality. Nationally, 6% to 8% of all births occur between 20 and 37 completed weeks of gestation. Infants who are born before 37 weeks of gestation account for 75% of all neonatal deaths in "normal" newborns. Despite a reduction of perinatal deaths over the past 30 years (from 20 to 12 deaths per 1,000 live births), the incidence of preterm births has not decreased significantly. In fact, certain high-risk groups have experienced an increase in the incidence of preterm births."[1]

Identifying high-risk patients is intended to help predict preterm labor and, ultimately, to prevent preterm birth. In France, the premature birth program developed by Papiernik resulted in a 42% decrease in the preterm birth rate (6.46% to 3.76%) over a 10-year period.[2] The program included scoring and assigning patients according to their risk. A report by Yawn and Yawn about preterm birth showed the value of patient instruction in self-detection of early signs of preterm labor and delivery.[3] The program also provided intensive in-service education for obstetrical staff.

In 1982, Robert Creasy, M.D., published his initial report of a prematurity prevention program modeled after Papiernik's.[4] The Creasy program owed its success to earlier identification of preterm labor.[4,5]

In Minnesota, successful programs have been in place since 1984.[3,6-8] Yawn and Yawn reported on rural programs in 1989, and in 1990 Fangman et al. conducted a study of 4,600 patients of two large managed care organizations that delivered babies in three hospitals.[7]

The New Pregnancy Assessment Form

By 1990 clinics had become inundated with a variety of preterm birth prevention assessment forms created by health plans, provider groups, and the Minnesota Depart-

ment of Human Services. The following year, the Minnesota Council of Health Plans (formerly known as the Minnesota Council of HMOs), the Minnesota Department of Human Services, and the Minnesota Medical Association began working together to design a single form that could be used statewide.

The new form asks providers to assess medical and psychosocial factors that contribute to poor birth outcomes. The committee defined poor pregnancy outcomes as any of the following: 1) delivery before 37 weeks completed gestation; 2) stillbirth; 3) infant weight less than 2,500 g; 4) five-minute Apgar score of less than 3; 5) admission of infant to special care nursery; 6) newborn hospital stay longer than five days; 7) infant death in first 28 days; or 8) maternal death.

To overcome some of the past problems with risk assessment forms, the committee determined the following:

- The form should be administered by health care professionals and staff. To minimize translation time and to increase accuracy of the responses, the form should not be self-administered.
- The form is only a first-level screening tool. Providers should follow up with additional questions to assess potential risks more thoroughly, especially relating to substance abuse and family violence.
- The form will require periodic updating to reflect current research concerning pregnancy risk assessment.
- Rather than using a numerical score, the form directs the provider to assess risk as present or absent. Research indicates that numerical scoring is difficult to use.[9]

The form was tested at sites throughout Minnesota. The committee sent it for comment to all physicians and nurse midwives who indicated on their license applications that they provide obstetrical services. The form was modified based on the providers' comments.

Physicians and certified nurse midwives throughout Minnesota received a training manual and copies of the assessment form. The training manual was approved by Allina Health System for CME/CMU credit. All definitions required to complete the form are in the manual and are printed in an abbreviated format on the reverse side of the assessment form. Assessment forms are provided to physicians at no charge. The manual outlines each health plan's policies about how physicians should submit the forms and its reimbursement policies for completing the form.

If a woman's pregnancy is determined to be at risk, health care providers can help the woman access services through her health plan and the Minnesota Department of Human Services.

In response to providers' concerns about how to meet the needs of at-risk pregnant women identified during the assessment process, public health nurses developed a directory of resources in each county to whom providers can refer pregnant patients. The directory is available through health plans with whom providers contract.

The pregnancy assessment form is a uniform tool for predicting poor pregnancy outcomes in Minnesota. The Minnesota Department of Human Services and the following members of the Minnesota Council of Health Plans have agreed to use this standard form: Allina Health System (Medica), Blue Cross and Blue Shield/Blue Plus of Minnesota, Central Minnesota Group Health Plan, First Plan of Minnesota, HealthPartners, Mayo Health Plan, Metropolitan Health Plan, and UCare Minnesota.

This successful collaborative effort will improve the care of pregnant women throughout Minnesota. MM

Pamela Weiss is education specialist at the University of Minnesota Center for Spirituality and Healing. Peter Mark is an obstetrician and gynecologist at HealthPartners.

REFERENCES

1. Fairview Physician Associates. Clinical pathways guidelines preterm birth prevention manual. Minneapolis: Fairview Physician Associates, 1996.
2. Papiernik E, Bouyer J, Dreyfus J, et al. Prevention of preterm births: the perinatal study of Hagnenau. Pediatrics 1985;76:154-8.
3. Yawn BP, Yawn RA. Preterm birth prevention in rural practice. JAMA 1989;252:230-3.
4. Herron MA, Katz M, Creasy RK. Evaluation of preterm birth prevention program: preliminary report. Obstet Gynecol 1982;59:295.
5. Holbrook RH, Laros R, Creasy RK. Evaluation of risk scoring system for prediction of preterm labor. Am J Perinatol 1989;1:62-8.
6. Mark PM, Eggen D. Group Health program to reduce the incidence of preterm deliveries. Minn Med 1984;67:509-10.
7. Fangman JJ, Mark PM, Pratt L, et al. Prematurity prevention programs: an analysis of success and failures. Am J Obstet Gynecol 1994;170:744-50.
8. Mark PM, Eggen D, Barosso G, Rourke MJ, Aksoy MM. Reduction of preterm birth in an HMO. HMO Pract 1989;3:199-204.
9. Wall EM. Assessing obstetric risk: a review of obstetric risk-scoring systems. J Fam Pract 1988;27(2):153-63.

Creating a Statewide Immunization Registry

A Tool for Physicians and Public Health

Martin LaVenture, M.P.H., Myrlah Olson, B.S.N., M.P.H.,
Bill Brand, M.P.H., and Byron Crouse, M.D.

Editor's Note: *Immunization registries are an important tool in our struggle to provide timely immunizations to all children. In Minnesota, immunization rates are very high by school age, but the rates are often less than 75% in the children most needing protection—those from 6 months to 4 years of age. Parents, physicians, and payers have identified barriers to immunization. High on the list is lack of easily accessible and accurate information on a child's immunization status when the child comes into the health care system. Better information will help prevent missed opportunities, while recall and reminder systems will help parents keep their children on schedule. Without the means to combine data into community, county, state, and perhaps national databases, the information will remain incomplete and inaccurate. This article outlines activities of Minnesota physicians and public health personnel in developing immunization registries. Join us in supporting this effort.*

–Barbara P. Yawn, M.D., M.Sc.,
Series Editor

How can something so simple be so complex? Take the immunization record—a simple table of vaccines and dates. But to the busy physician and clinic staff, making sure that the record is complete and accurate can be surprisingly difficult and costly.

The immunization record not only helps determine the care of an individual child, but also provides critical information for assessing community immunization levels and ensuring that schools and child care providers are complying with state law. Timely delivery of immunizations, protection of children in schools and child care, and community health assessment all hinge on the immunization record.

Momentum is growing throughout the country to combine individual records into immunization registries—electronic databases that compile individual, community, state, or national immunization information for use by physicians, schools, parents, and researchers. Also known as immunization information systems or tracking systems, registries can be provider-based, containing the records for all children in one practice, or community, county, state, or national registries, combining the immunization records for all the children in a geographical area, regardless of where immunizations were received.

The Benefits of a Registry

Everybody benefits from an immunization registry. With a registry in place, families will be able to maintain immunization records even when they move or change insurance plans or physicians. The risk of under- or overimmunization will be reduced. Immunization reminders and follow-up notices will help parents keep their children on schedule, and parents will find it easier to provide immunization records to child-care facilities, camps, and schools.

Physicians and other health care providers, managed care organizations, schools, and child-care facilities will spend less time searching for immunization records. The waste and risks of unnecessary immunizations will be reduced.

Communities will benefit from the availability of current data to evaluate and monitor immunization status and the effectiveness of immunization services, outreach, and education. Because pockets of need will be identified easily, public health officials can target outreach and education resources to the most critical audiences.

The Minnesota Model for Community-Based Registries

Several factors spurred the development of immunization registries in Minnesota: the measles outbreaks of the early 1990s, the increasing complexity of the recommended childhood immunization schedule, family mobility, and technological expansion. Based on the recommendations of the Minnesota Department of Health Immunization Practices Task Force, Work Group on Immunization Registries, the Minnesota model for community-based immunization registries emerged. Guided by

six principles, the model's overarching goal is to permanently improve the system of immunization delivery, documentation, and assessment.

1. Local development of community registries based on local needs.

Each community in Minnesota will shape its immunization registry according to local needs. For example, an area bordering another state must deal with the issue of children who live in one state but receive immunizations in the other. A part of the state with a large migrant worker population might face the dilemma of incomplete immunization records because some children received shots in Texas or Mexico. An urban area with a large number of poor children has different needs than an affluent suburban area.

2. A consistent set of core information for each record.

Although registries will be shaped locally, to be linked statewide they must all collect the same core data. If Duluth collects oranges while Austin collects apples, there will be no benefit to linking their registries. The core set of data for each immunization record established by the MDH Work Group on Immunization Registries includes information needed to identify the patient and the type of immunization given.

3. An emphasis on accurate, complete data.

High standards for data quality will be maintained through both electronic and human checks and systems that ensure the accuracy of the data before it enters the registry. A recent study of VacAttack, the Delaware registry, found its information more reliable than parent records.[1]

4. Clinics can participate in the registry without costly equipment upgrades.

Although electronic medical records may be on the horizon, they are not here yet for most clinics. Many clinics use computers only for billing and would not participate in an immunization registry if it meant buying new computers and spending time and money to train staff to use them. For that reason, the Minnesota model is technologically flexible, encouraging participation with any level of technology, including paper-based records.

A good example of this principle in action is the Southwest Immunization Information System (SIIS), a not-for-profit organization operating in seven counties of southwestern Minnesota. SIIS clinics provide 97.5% of the immunizations in the seven counties; the system will eventually include 20 counties.

Children are enrolled in SIIS through birth records, clinics, WIC, parents, and other sources. Clinics can submit immunization reports electronically, but most prefer to use paper reports. SIIS maintains records, notifies parents and clinics when immunizations are due, and helps child-care facilities and schools comply with immunization laws. In addition, the system produces reports that include practice-specific (HEDIS) and population immunization levels.

SIIS works with staff in each clinic to develop a system tailored to each clinic. This customized approach has resulted in high clinic participation, and immunization levels in the participating counties have increased by as much as 27% from preregistry levels. Because it is technologically flexible and responsive to clinic needs, this community-based model is being considered in much of rural Minnesota.

Another approach is the online immunization registry system being developed by St. Paul-Ramsey County Department of Public Health and the Hennepin County Community Health Department. Participating clinics will be able to access their patients' immunization records via a password-protected system, which will also include records from local public health clinics and other providers.

5. Linking community and state registries.

As beneficial as the community registries will be, the full value of the system will be realized when they are linked to each other and to registries in other states.

The Minnesota Department of Health, with the help of the Health Informatics Program at the University of Minnesota, is planning a system that will facilitate information sharing between authorized users. (Minnesota state law allows providers, schools, public health agencies, and parents or legal guardians to share immunization data.[2])

continued

Proposed Core Information for Immunization Registries

Patient name
Birth date
Gender
Street address
City, state, zip code
Mother's name
Immunization date
Vaccine type
Vaccine manufacturer
Vaccine lot number
Name of clinic providing immunization
Immunization adverse reaction indicator
Contraindication indicator

Minnesota statutes (144.3351) allow the exchange of this information between providers, public health, and specified others.

The Centers for Disease Control and Prevention has recently recommended core data sets for state immunization information systems. They are published on the World Wide Web at http://www.cdc.gov/nip/registry/siteidx.html#guide.

6. HIGH SECURITY STANDARDS TO MAINTAIN CONFIDENTIALITY.

Immunization registries are governed by the same principles of confidentiality, privacy, and security that pertain to medical records. Preventing unauthorized users from accessing the data while making it easy for physicians and other authorized users to get the information they need is the goal.[3] Electronic and paper records require different security measures, but the principles remain the same.

The major threat to the security of electronic databases may not be the hacker who breaks into the system, but rather the people working with the system. Are passwords changed regularly? How "secret" are they? Are reports and other materials shredded or locked up? Are offices locked when unattended? Does the staff understand security procedures? These questions can be addressed through regular communication and training.

PHYSICIANS ARE CRUCIAL TO REGISTRY SUCCESS

Nearly every county in Minnesota is working on a community registry. In most places, the local public health agency is coordinating the registry development. In the Twin Cities, the Center for Population Health is studying options for a community registry in the seven-county metropolitan area.

Experience throughout the country shows that active and early physician participation in registries is vital.[4] This is particularly true in Minnesota, where 90% of childhood immunizations are given by private physicians. The Minnesota Department of Health, together with SIIS, the St. Paul-Ramsey County Department of Public Health, and the university's Health Informatics Program, has been awarded a CDC grant to study the barriers and benefits to private provider participation in immunization registries. The last phase of the two-year grant will focus on increasing physician participation in Minnesota registries.

Just over 200 years ago, Edward Jenner administered the first vaccine. Although it took another 100 years for a second vaccine to be developed, we have learned that the most difficult task is not developing vaccines but assuring they reach all children.[5] Our ultimate goal in Minnesota is to eliminate vaccine-preventable disease. Immunization registries are a powerful tool that will help us move toward that goal.

For more information about immunization registries in your county, call your local public health agency, or call the Minnesota Immunization Hotline at 800/657-3970 or 612/623-5100. MM

Martin LaVenture is manager of the Acute Disease Prevention Services Section at the Minnesota Department of Health. Myrlah Olson is instructional designer of the Acute Disease Prevention Services Section. Bill Brand is community health planner of that section. Byron Crouse is associate professor and head of the Department of Family Medicine at the University of Minnesota–Duluth School of Medicine and chair of the MDH Work Group on Immunization Registries.

REFERENCES

1. Ortega AN, Andrews SF, Katz SH, et al. Comparing a computer-based childhood vaccination registry with parental vaccination cards: a population-based study of Delaware children. Clin Pediatr 1997;36:217-21.
2. Minn. Stat. § 144.3351 (1996).
3. Gostin LO, Lazzarini Z. Childhood immunization registries: a national review of public health information systems and the protection of privacy. JAMA 1995;274:1793-9.
4. Pappas M, Baker B, Appelbaum D, Hinds W, Alexander ER, Korolak, K. Immunization registries: provider recruitment and participation. Prev Med 1997 (Suppl);13:71-6.
5. Foege WH. Foreword to developing immunization registries: experiences from the All Kids Count program. Prev Med 1997(Suppl.):1-2.

Urgent Care Physicians

Urgent care openings at five Procare sites throughout the Twin Cities. BE/BC Family Practitioners and Internists, comfortable with pediatrics, to work evenings, weekend, and holidays. Permanent part-time (32-40 hours every two weeks) with benefits. Moonlighting needed and will consider residents.

MERCY & UNITY HOSPITALS
ALLINA HEALTH SYSTEM

For more Information:
Debbie Modder
Allina Health System
5601 Smetana Drive Route 80775
612-992-3094 / 800-284-4921
Fax: 612-992-2927

Minor Consent to Treatment

Physicians need to know when they can, and when they cannot, treat a minor without the consent of a parent or legal guardian.

Kimberly Halva, J.D., M.P.H.

Today the risks to child and adolescent health are not purely biomedical. Minors face a growing risk of disease and injury resulting from violence, drug and alcohol use, and unprotected sex.[1] Consequently, minors are seeking treatment for increasingly sensitive issues and are asking their physicians not to seek their parents' consent. To meet the changing needs of their minor patients and, at the same time, comply with the law, physicians need to know the rules related to a minor's right to consent to treatment.

Generally, in non-emergencies physicians must obtain the consent of a minor's parent or legal guardian before beginning treatment. However, for some types of treatment and in certain situations, minors may give effective consent.*

Emergency Treatment

Physicians do not need the consent of a minor's parent or legal guardian to begin treatment in emergency situations; their consent is implied. Minnesota law allows physicians to render health services to any minor without the consent of a parent or legal guardian when the physician believes the risk to the minor's life or health demands it, and he or she believes obtaining consent would result in delay or denial of treatment.[2]

In addition to situations that a physician would consider emergencies when treating an adult, emergencies for a child may also include any condition that requires prompt treatment to alleviate pain or for which delay of treatment could increase the risk to the minor's health.[3] For example, a young child with a broken arm is brought into the emergency room by her neighbor. The child is in severe pain, but the neighbor cannot immediately locate the child's parents. The physician could probably begin treatment without the consent of the child's parent. The physician should, however, make every effort to notify the child's parents or legal guardian as soon as possible.

Treatment for Pregnancy and Venereal Diseases

Minors may also give effective consent to most health services related to pregnancy and venereal diseases. Minnesota law specifically states that any minor may give effective consent for medical, mental, or other health services to determine the presence of or to treat pregnancy and conditions associated with venereal disease—conditions a minor might be reluctant to discuss with a physician if the physician were required to notify the minor's parents. The consent of no other person is required.[4]

An exception applies when a pregnant minor seeks abortion services. In most circumstances, when a minor seeks an abortion, her parents must be notified in writing 48 hours before the abortion is performed.[5] A physician *may* provide abortion services to a minor without notice to the minor's parents if the physician certifies in the medical record that an abortion is necessary to prevent the girl's death; if her parents provide written authorization for abortion services prior to notification; or if the minor declares she is a victim of sexual abuse and notice is given to the proper authorities.[6] A judge or court may also waive the parental notification requirements if the judge or court determines that the pregnant girl is mature and capable of giving informed consent to the proposed abortion.[7]

Treatment for Alcohol or Drug Abuse, and Hepatitis B Vaccinations

Minors may also give effective consent for treatment of alcohol or drug abuse. A Minnesota law enacted in 1971 allows minors in Minnesota to give effective consent for medical, mental, or other health services to determine the presence of or to treat alcohol and other drug abuse.[4] This statutory exception encourages mi-

*This article does not address a minor's ability to consent to the administration of intrusive mental health treatments and psychotropic medications or to sterilization. Nor does it address a minor's ability to consent to participation in research. These situations raise complex issues and may require special consent. Physicians should contact an attorney if questions about these types of consent arise.

First Call Physicians, Inc.
A Locum Tenens Service
500 Eighth Ave. S.
Buffalo, MN 55313

Clinics/Hospital | **Physicians**

Locums Coverage
=
Revenue

- Patients falling through the gaps?
- Physician burn-out or illness?
- Shortage of physicians?

- Earn more with less time.
- No administrative headaches.
- Malpractice premium paid.

Experience, Service, Honesty
Call (metro) 682-3852
(toll free) 888-682-3852

(You'll be glad you did!)

ASPEN Medical Group

Full Time Urgent Care
Internal Medicine

Opportunities available for BC/BE physicians to join multispecialty group governed and managed by its own physicians and health care providers. Aspen's commitment to quality care and personal service is shared by 165 professionals who offer care at 10 clinic locations in the Twin Cities. Guaranteed base salary and attractive benefits package. Please contact:

Nancy Borgstrom
Aspen Medical Group
1021 Bandana Blvd. E. #200
St. Paul, MN 55108
612-642-2779
FAX 612-642-9441

nors addicted to alcohol and drugs to seek treatment, which they might not readily do if their physician had to notify their parents.

Similarly, Minnesota law also allows minors to give effective consent to vaccinations for hepatitis B, a serious and growing health problem among adolescents. The consent of no other person is required.[8]

Emancipated Minors

Regardless of the statutory exceptions stated above, *emancipated* minors may consent to any type of treatment without the consent of their parent or legal guardian. The term emancipated minor refers to a minor who is: 1) living apart from his or her parents and is managing his or her own financial affairs; 2) is married; or 3) has given birth.[9]

An emancipated minor can make decisions, including those about health care, as if he or she were an adult. Most children or adolescents living at home with their parents do not meet the definition of an emancipated minor. A minor who lives apart from his or her parents, however long the separation, and who manages his or her own financial affairs, regardless of the source or extent of income, is an emancipated minor.[10] Similarly, an unmarried adolescent mother living with her parents is emancipated, as are two married minors living with their parents. The minors in all of these situations can consent to their own medical treatment.

Informed Consent, Medical Records, and Payment

When a minor is allowed to consent to his or her own treatment, the physician is obligated to obtain *informed* consent from the minor. There is a subtle difference between consent to treatment and informed consent. Consent to treatment refers to an individual's agreement to undergo a procedure or a course of treatment. Informed consent refers to the amount of information a patient needs to know about a procedure or course of treatment for his or her consent to be legally effective. In virtually every circumstance, the consent to treatment by a minor should be informed consent. This means that the physician should advise the minor fully as to the treatment's risks, benefits, and likelihood of success before getting the minor's consent.

When a minor has consented to treatment, the physician must obtain the minor's consent before releasing any of the minor's medical records related to that treatment—no matter who is seeking access. A parent or legal guardian may have the authority to access some portions of the minor's medical record without the minor's consent; they do not have the authority to access the portions of the record that concern treatment consented to by the minor, unless the minor agrees.

Finally, a minor who consents to treatment should expect to pay for it. According to Minnesota law, physicians who provide health services to a minor who has legally consented to those services can collect payment directly from the minor.[11]

Conclusion

Increasingly, minors are asking their physicians to treat them without the consent of their parents or legal guardians. To best serve these patients, physicians need to know when they can, and when they cannot, legally treat a minor without the consent of the minor's parent or legal guardian. MM

Kimberly Halva is the associate legal counsel at the Minnesota Medical Association.

This article is designed to alert physicians to issues they may encounter when treating adolescents. It is not legal advice and should not be relied upon as such.

REFERENCES

1. Wilson MD, Joffe A. Adolescent Medicine (Contempo 1995). JAMA 1995;273(21):1655-7
2. Minn. Stat. § 144.344 (1996).
3. MacDonald MG et al., Treatise on Health Care Law § 19.03(a) (1997).
4. Minn. Stat. § 144.343, sub. 1 (1996).
5. Minn. Stat. §144.343, subd. 2 (1996).
6. Minn. Stat. §144.343, subd. 4 (1996).
7. Minn. Stat. §144.343, subd. 6 (1996).
8. Minn. Stat. §144.3441 (1996).
9. Minn. Stat. §144.341 (1996); Minn. Stat. § 144.342 (1996).
10. Minn. Stat. §144.341 (1996).
11. Minn. Stat. § 144.347 (1996).

TROCKMAN

continued from page 9

Using a Multidisciplinary Approach

Trockman attributes many of CBLC's successes to the multidisciplinary approach the clinic uses. When a child is referred to the clinic, a team of five professionals performs a two- to three-day assessment. As the physician in charge, Trockman evaluates the medical needs of each child, who is also evaluated by a psychologist, a speech pathologist, a special education teacher, and a social worker.

The detailed assessment covers five main areas:

- Medical and neurological: The physicians conduct a medical and developmental history, as well as a child interview and physical and neurologic exams. Vision and hearing tests are performed, along with a urine test to screen for metabolic disorders. Other tests, such as an EEG, may be performed if needed.
- Psychological: The clinic's psychologist provides testing and counseling.
- Speech and language: A speech-language pathologist tests attention and language. The results may lead to consultation with school personnel regarding classroom and treatment strategies.
- Educational: A special education teacher helps interpret test information and consults with school personnel to identify teaching techniques and develop plans for managing behavior.
- Social services: The clinic's social worker acts as the facilitator during the assessment, implements recommendations, and sometimes meets with the child and parents to provide support or counseling.

The CBLC specialists meet after the assessment to prepare reports and develop recommendations for the child. Trockman says it is important that they all agree on a unified course of treatment.

"Our purpose is to present a cohesive, meaningful picture. We're not trying to just make a diagnosis. We want to look at the child's strengths. If the child has deficits, we want to find out what those deficits mean. If the child persists in self-defeating behaviors, we want to put them into context."

The CBLC staff then meets with schoolteachers and administrators to recommend an individual education plan. The child and parents usually participate in this meeting. Once all parties agree on a course of action, the school and parents implement the recommendations. CBLC's active involvement stops at this point, although the clinic staff remains available for consultation and to monitor medications.

Keeping the Clinic in Operation

Funding limits the number of patients the clinic can accept. CBLC's $280,000 annual budget comes from Hennepin County and the Minneapolis Public Schools. Across-the-board cuts in the Minneapolis special education budget this year forced cutbacks in staff time at the clinic, and Trockman says funding remains fragile.

"Everything we do is outpatient," Trockman says, "and outpatient reimbursements are not strong. Another problem is that our diagnoses are considered mental health, and insurance companies and managed care organizations put limits on mental health reimbursements, so we end up giving away a lot of service."

Despite 26 years of continuous operation, the Child Behavior and Learning Clinic struggles each year to find the resources to stay open. Nonetheless, Trockman maintains a determined optimism about keeping the clinic available for children in Hennepin County.

"We have to," she says. "The private sector finds it very difficult to do what we're doing."

Taking the Circuitous Path

Trockman admits that she took a circuitous path to arrive at her life's work. She received her undergraduate degree from the University of Minnesota with majors in psychology and chemistry and a minor in math. Trockman gave serious thought to becoming a clinical psychologist. But the quiet, thoughtful M.D. shrugs and says, "Somewhere along the way I forgot about psychology and went into medicine."

Trockman decided to specialize in pediatrics, but she realized that general pediatrics wouldn't be enough to satisfy her.

"It bothered me to see medical care given with a narrow focus," she says. "I kept wrestling with wanting to know the context in which people lived, and not just what to do about their stomachaches or headaches. As I went through my medical education, I realized I was seeking the big picture."

Trockman credits A.B. Baker, a professor of neurology at the University of Minnesota, with teaching her how to bring the big picture into focus.

"He told us we had to take care of the whole patient, and he gave us a system for thinking about it," Trockman says. "He reminded us to consider multiple factors: the mind, the body, where you were, the circumstances surrounding you. I knew, after I finished my training in pediatrics, that I wanted additional training in neurology."

Trockman, who has raised three sons with her husband, recently retired Minneapolis Public Schools administrator Mitchell Trockman, says being a mother has also helped her see the big picture and has made her a more honest pediatrician.

"When I first started practicing, I idealized what parents could accomplish," she says. "When a child wasn't doing well, I wanted to be parental toward the parent and scold them into shape. I identified with the child. My sympathies shifted after I became a parent myself and understood how impossible it was to be perfect. You can make a lot of mistakes and your children can still turn out OK. That's the way it is in my family: lots of mistakes, wonderful children." MM

Jeremiah Christopher Whitten is a writer and media relations consultant specializing in health care and high technology.

People and Places Making Medical News

People

Distinguished Career Award

Mark Nesbit Jr., M.D., has received the American Society of Pediatric Hematology-Oncology Distinguished Career Award. Nesbit, a physician with the University of Minnesota Cancer Center, has played a major role in designing clinical studies for children with acute leukemia, bone tumors, and histiocytosis. In addition, he has been involved in spawning the career of more than 50 pediatric hematologists-oncologists who have gone on to become leaders in their field. He played a major role in developing the university's pediatric hematology/oncology program and was instrumental in establishing the Ronald McDonald House of the Twin Cities.

Planned Parenthood Physician of the Year

Planned Parenthood of Minnesota/South Dakota selected **Miriam McCreary, M.D.,** of St. Paul for its Physician of the Year Award, given to a physician who exemplifies excellence in patient care and a commitment to the mission of Planned Parenthood. In addition to working with Planned Parenthood's clinic in the Highland Park neighborhood of St. Paul, McCreary has a private ob/gyn practice in St. Paul.

Genetic Research Award

The University of Minnesota's **Robert Gorlin, D.D.S., M.S., D.Sc.,** has received the International Phoenix Anni Verdi Prize for Genetic Research. Given by the Italian Association of Medical Genetics, the prize is considered the top annual award in genetics. In addition, the Institute of Medicine, a division of the National Academy of Sciences, has chosen Gorlin as a senior member in recognition of his work.

Gorlin, a Regents' Professor Emeritus of Oral Pathology, has discovered about 80 syndromes, including Gorlin syndrome. He has studied dwarfism extensively and helped organize Little People societies in various states and countries.

Hennepin Medical Society Leadership

The Hennepin Medical Society recently announced its new leaders for the upcoming fiscal year: **Chair William F. Schoenwetter, M.D.,** Allergy & Immunology, Park Nicollet Clinic, St. Louis Park; **President Edward A.L. Spenny, M.D.,** internal medicine, Columbia Park Medical Group, Columbia Heights; **President-Elect David L. Estrin, M.D.,** pediatrics, South Lake Clinic, Minnetonka; **Secretary Richard M. Gebhart, M.D.,** family practice, Camden Physicians, Maple Grove; and **Treasurer Virginia R. Lupo, M.D.,** ob/gyn, Hennepin County Medical Center, Minneapolis.

Medical Alley Board Members and Officers

Medical Alley, the St. Louis Park-based trade association for Minnesota's health care industry, elected new board members and officers at its 10th annual meeting in October. The board, which consists of 29 directors who represent the breadth of the industry, is responsible for determining and implementing ways the association can achieve its mission of enhancing the health care industry's operating environment.

The newly elected directors are **David Cress,** North Memorial Health Care; **Dale Thompson,** Health Dimensions; **Steve Kelmar,** Medtronic, Inc.; **Frank Cerra, M.D.,** University of Minnesota; **Craig Howe,** National Marrow Donor Program; **Joel Koemptgen,** SMDC Health System; **Robert Meiches, M.D.,** Minnesota Medical Association; **Marcus Merz,** Preferred One; **Joe Schiesl,** Value Rx; **Mark Skubic,** HealthSystem Minnesota; **Steve Wetżell,** Buyers Health Care Action Group.

The elected officers are **Board Chair James Dixon,** vice president of regional hospital partnerships, HealthPartners; **First Vice Chair Jerry Haarmann,** chief executive officer, Memorial Blood Centers of Minnesota; **Second Vice Chair Marlene Travis,** president and chief operating officer, Health Risk Management, Inc.; **Treasurer James Ravell,** partner, Grant Thornton LLP; **Counsel Margo Struthers,** attorney, Oppenheimer Wolff and Donnelly; and **President Thomas Meskan,** executive director, Medical Alley.

Places

CME Awards

The Minnesota Medical Association's Continuing Medical Education Accreditation Program presented certificates of award to the following CME sponsors, which have been accredited by the MMA for 20 years: Children's Health Care, St. Paul; St. Mary's/Duluth Clinic Health System, Duluth; Immanuel-St. Joseph's–Mayo Health System, Mankato; Methodist Hospital–Health System Minnesota, Minneapolis; Rice Memorial Hospital, Willmar; and Ridgeview Medical Center, Waconia.

Also receiving certificates of award were **Charles N. Bean, M.D.,** director of medical education at Ridgeview Medical Center, and **Nancy Bergner,** CME coordinator at North Memorial Health

Care, Robbinsdale. Both have served 15 years or longer at MMA-accredited organizations.

Former Senator Resigns as Mayo Board Chair

Former U.S. Sen. Howard Baker resigned as chair of the Mayo Foundation board of trustees after Mayo discovered that five tobacco companies have hired his Washington, D.C., law firm to lobby Congress. Although Baker said he did not see any conflict of interest, his connection to the tobacco industry angered many Mayo physicians, who pointed out that the clinic has been a national leader in antismoking efforts. The tobacco companies hired Baker's firm to lobby Congress to accept the tobacco industry's proposed $368.5 billion settlement of the lawsuits filed by dozens of states to recover tax money spent treating smokers.

In a letter to Mayo Clinic staff, Robert Waller, M.D., president of the Mayo Foundation, and Robert Hattery, M.D., chair of the Mayo board of governors, said Baker chose to resign "rather than allow any perception of conflict to adversely affect the institution." They also said they believe it is "essential that no circumstances exist that could compromise the ability of Mayo physicians to address the hazards of tobacco use."

HealthPartners Goes Online with Health Provider Database

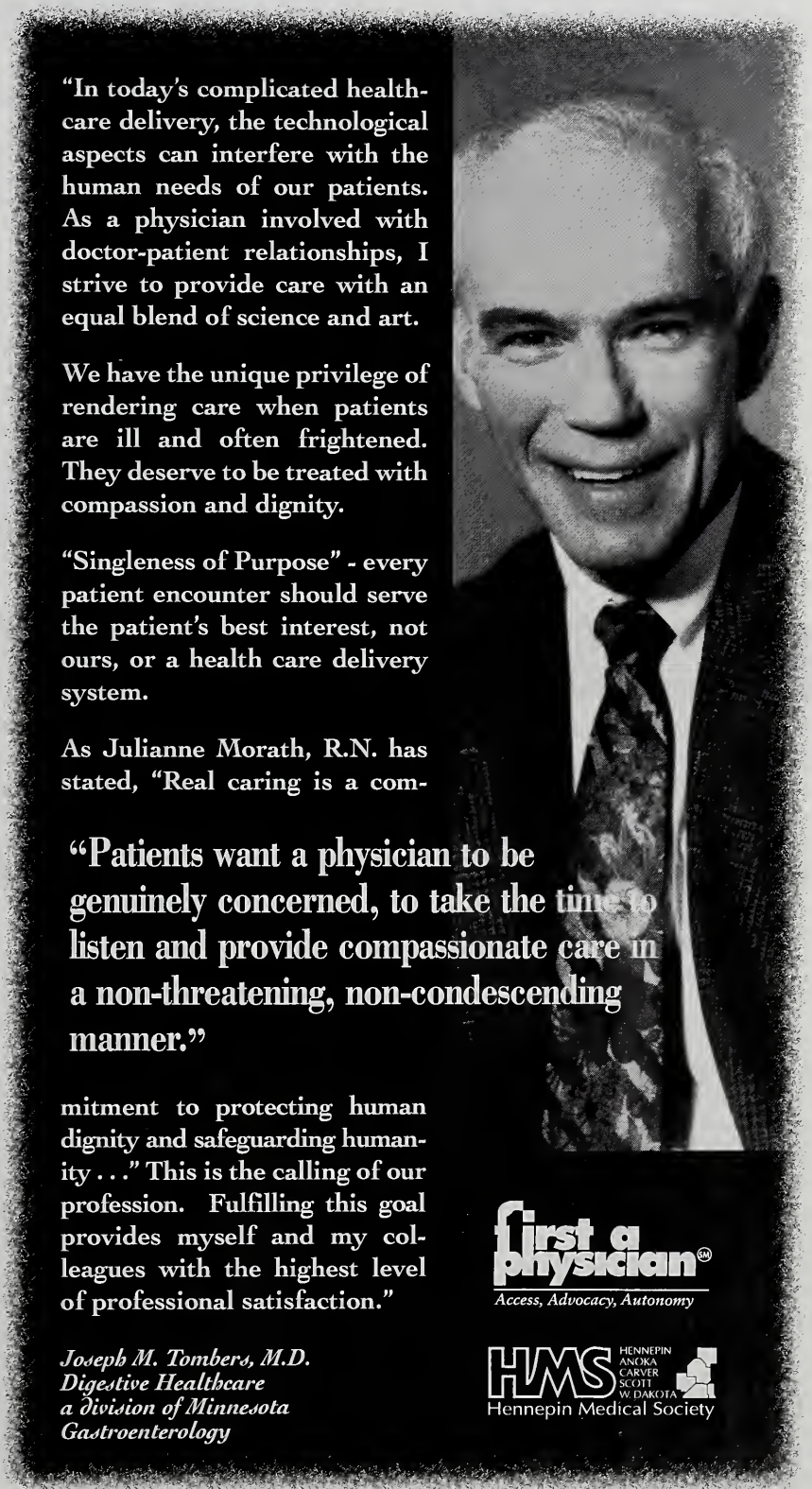
HealthPartners has put its "Consumer Choice" database on the World Wide Web so the public can review its reports of physician qualifications and the results of its patient satisfaction surveys.

"As a consumer-governed organization, we believe consumers should have the data they want and need to help make their decisions about choosing health care providers," said George Halvorson, HealthPartners president and chief executive officer.

Consumer Choice Web address: www.consumerchoice.com. HealthPartners Home Page address: www.healthpartners.com.

Public Health Institute Wins Grant

The Minnesota Institute of Public Health, based in Anoka, Minnesota, has received a $1 million grant for each of the next three years from the Department of Health and Human Services to implement research-based community drug prevention strategies throughout the Midwest. Institute president



Multicare Associates of the Twin Cities, a multi-specialty/multi-location clinic, located in the northern suburbs of Minneapolis/St. Paul has available positions for BC/BE physicians in the following departments:

Family Practice
Occupational Health
Ob/Gyn
Pediatrics

Excellent salary/benefits package includes paid insurance, flexible benefits plan, 401K, profit sharing, continuing medical education. Shareholder status potential after one year.

Contact Jeannine Schlottman
Administrator
7675 Madison St. NE
Fridley, MN 55432
612/785-3338

MULTICARE ASSOCIATES OF THE TWIN CITIES

Weigh The Facts!

Benefits to clinics, hospitals and practitioners include:
-Large pool of seasoned physicians.
-Integral part of medical referral network.
-Current in medical care policies, procedures and protocol.

To physicians of all specialties:
-Confidentiality prioritized.
-Financial incentives.
-Medical malpractice.
-Personalized service tailored to your needs.



Whitesell
Medical Locums, Ltd.

Eight First Avenue South
Buffalo, MN 55313
1(800) 876-7171
1(800) 295-6373
Local 682-5218 or 682-5906
FAX (612) 682-4791

Jerry Jaker said the money will be used to assess and improve adolescent drug abuse programs in a 10-state region.

Abbott, United Receive Perinatal Ultrasound Certification

Abbott Northwestern Hospital's Perinatal Center and United Hospital's Maternal Fetal Medicine Clinic are the first practices in Minnesota to receive a joint accreditation from the American Institute of Ultrasound in Medicine's Ultrasound Practice Accreditation Commission. The three-year accreditation recognizes that the practices have met strict standards set by the diagnostic ultrasound profession.

Judy Ney, M.D., is the associate medical director of Abbott Northwestern's Perinatal Center, and **Pat Mills, M.D.**, is the associate medical director of United's clinic. **Deb Brandt, R.D.M.S.**, is the perinatal ultrasound manager for both facilities.

Socioeconomics

Merger Unites Red Wing Health Care Groups with Fairview

The creation of Fairview Red Wing Health Services became official in November with the signing of documents to merge River Region Health Services, Interstate Medical Center, and Fairview Health Services. The merger creates Fairview's fourth health care region outside the Twin Cities, with others in Princeton, Chisago/Forest Lake, and Hibbing. Each includes a hospital, clinics, and other services.

Researchers: MinnesotaCare a Success

MinnesotaCare has been successful in providing health insurance to the state's uninsured, particularly children, reported **Kathleen Call, Ph.D.**, and **Nicole Lurie, M.D.**, in the October 8 *Journal of the American Medical Association.* Because of the program, the proportion of children who remained uninsured for 12 months or more dropped from 5.2 percent in 1990 to 3.1 percent in 1995. The proportion of Minnesotans without health insurance remained stable at 6 percent from 1990 to 1995, while the national rate of uninsurance increased from 13.9 percent in 1990 to 15.2 percent in 1994.

"Overall, [MinnesotaCare] has been tremendously successful," Lurie told the St. Paul *Pioneer Press.* "I don't think there's any doubt that it should be a national model. It's something the state should feel very, very proud of, even with its warts."

HMOs Losing Money

The state's nine HMOs reported a collective operating loss of $53.9 million for 1996, following a loss of $3.2 million in 1995, according to the *Minnesota Managed Care Review 1997* by health care consultant **Allan Baumgarten.** The report predicts premium increases as high as 23 percent for 1998.

The losses came despite a slight increase in premium revenue, from $2.24 billion in 1995 to $2.45 billion in 1996. The biggest increase in expenses for the HMOs was for prescription drugs, said **David Strand,** president of Medica.

Health Plans Starting Joint Consumer Initiative

The Minnesota Council of Health Plans is joining the Minnesota Center for Health Care Ethics and the Minnesota Institute of Public Health to educate consumers about managed care decisions and to gauge the community's values and expectations for health care. The program, called EQUIP (ethics, quality, information, and prevention), will publish a report on how the quality of health care is measured and other data on Minnesota health plans.

"What we are struggling with is how do we connect with the community at large to get at the values of the community?" said **Michael Scandrett,** executive director of the council, in a Twin

Cities-based *Star Tribune* article. "What do they want from the health plans?"

Minnesota Health Plans to Use National Experts for Appeals

Medica Health Plans and HealthPartners have contracted with outside consulting firms to review patient requests for investigational treatments. Both plans will use the Bethesda, Maryland-based Medical Care Ombudsman Program, a national network of expert physicians; HealthPartners will also use ECRI of Plymouth Meeting, Pennsylvania.

The expert panels will decide whether requested care is experimental or has moved beyond the experimental stage and qualifies for coverage under the health plan. Both plans say they will accept the panels' decisions as binding.

Many health plans across the country have begun using such external review firms to increase plan enrollees' confidence in their decisions. According to **Michael** Scandrett, executive director of the Minnesota Council of Health Plans, all 11 members of the council have discussed adopting external review mechanisms.

Rates, Trends, Data

Survey Finds High Patient Satisfaction with Health Plans

A survey conducted by the Buyers Health Care Action Group (BHCAG), a coalition of more than 25 large employers, and the Minnesota Department of Employee Relations found that most employees of the state and BHCAG companies are quite satisfied with their clinics and health plans.

Of the health plans included in the survey, HealthPartners Classic, formerly the Group Health HMO, received the highest satisfaction rating, with 79 percent of respondents either extremely or very satisfied with the plan. The highest-rated clinics were St. Croix Valley Healthcare, Hennepin Faculty Associates, and Abbott Northwestern Physician Hospital Organization.

Researchers contacted 9,700 enrollees in Choice Plus, the health plan for BHCAG-member employees and their dependents, and 9,700 state employees. The survey asked state employees about seven health plans available to them. In addition, researchers contacted about 3,000 patients who use some care systems through medical assistance. Respondents were asked to evaluate health plans on 15 items, including access to specialists, the way members' phone calls are handled, and quality of care. Care systems were evaluated on 12 items, including overall quality and service, waiting time, and doctor attentiveness.

Overall, between 87 percent and 97 percent of those surveyed said they were satisfied or very satisfied with their care system. Between 65 percent and 79 percent of state employees said they were satisfied or very satisfied with their health plan. State Health Plan Select, a self-insured plan for the state administered by Blue Cross and Blue Shield of Minnesota, received the lowest rating. Sixty-five percent of respondents were either extremely or very satisfied with the plan.

Results of the survey are available on the World Wide Web at www.choiceplus.com and at www.umn.edu/hsr/doersurvey.html.

Surgery Rates Vary by Region

The likelihood that patients will undergo certain surgeries varies by region, according to the Dartmouth Atlas of Health Care, a new study of hospital spending and surgery among the nation's Medicare population. "The amount of care consumed by Americans is highly dependent on where they live—on the capacity of the health care system where they live, and on the practice styles of local physicians," the Atlas reported.

For example, mastectomy rates are the highest in the Midwest; knee replacement rates are highest in the Upper Midwest and the Rocky Mountain region. Back surgery is most common in California, the Northwest, and the Rocky Mountain area, as well as the Carolinas and parts of Florida and Texas. Certain cities also have rates that vary dramatically from the average. For example, Bend, Oregon, has one of the highest rates of back surgery in the nation—about 76 per 10,000 Medicare enrollees, compared with a national average of 29.

Medical Schools Admitting Fewer Minority Students

U.S. medical schools admitted fewer minority students this year, according to a study by the Association of American Medical Colleges. The number of African-Americans, American Indians, Mexican-Americans, Chicanos, and Puerto Ricans applying to the nation's 125 accredited medical schools for 1997 dropped 11 percent from 1996. In addition, 6.8 percent fewer minority students were accepted to the schools.

The numbers were down most for schools in California, where the state's electorate voted to end affirmative action in state institutions, and in Texas, Mississippi, and Louisiana, the states covered by the 5th U.S. Circuit Court of Appeals' decision that affirmative action is unconstitutional. In these four states, 17 percent fewer minority students applied to their state medical schools, and the number accepted dropped 27 percent.

"This is an ominous sign for the medical community and our nation, which badly needs a physician workforce that is both diverse and reflective of our society as a whole," said Jordan J. Cohen, president of AAMC.

Law & Policy

Minnesota Hospitals Included in Medicare Probe

At least six Minnesota hospitals are included in a national inquiry

checking for improper Medicare and Medicaid billing practices. The U.S. Justice Department and the state attorney general's office will review lab test charges at Abbott Northwestern and Hennepin County Medical Center in Minneapolis, Methodist Hospital in St. Louis Park, Regions Hospital in St. Paul, and the Mayo Clinic hospitals in Austin and Rochester. As *Minnesota Medicine* goes to press, at least 10 more hospitals are expected to be added to the list, according to the Minnesota Hospital and Healthcare Partnership (MHHP).

Hospital officials point out that the investigation does not imply wrongdoing; investigators may only be looking for billing errors. "We firmly believe that all that is going to be discovered in Minnesota is errors due to complexity and inconsistency in the regulations. We fully suspect that there will not be fraud," said MHHP attorney Stephen Rogness.

Medical Research

Health Care Professionals Can Influence Hope in Cancer Patients

Health care professionals can contribute to or lessen hope in cancer patients by the way they communicate, ultimately influencing the patients' ability to cope with the disease, University of Minnesota Cancer Center researchers have found. Results of their study were published in the October issue of *Oncology Nursing Forum*. The team, led by Janice Post-White, R.N., Ph.D., American Cancer Society Professor of Oncology Nursing, surveyed 32 patients undergoing cancer treatment at Fairview-University Medical Center in Minneapolis. Some of the patients had been referred to university physicians from other states. Patients were asked a series of questions related to hope, four of which targeted the health professional's role.

Overall, 17 of the respondents said their health care professional did not decrease their level of hope. Fifteen said their health care professional's willingness to take the time to talk increased their level of hope; 13 said their hope was increased because information was given in a sensitive manner, and 12 said their hope increased because the caregiver was friendly or polite.

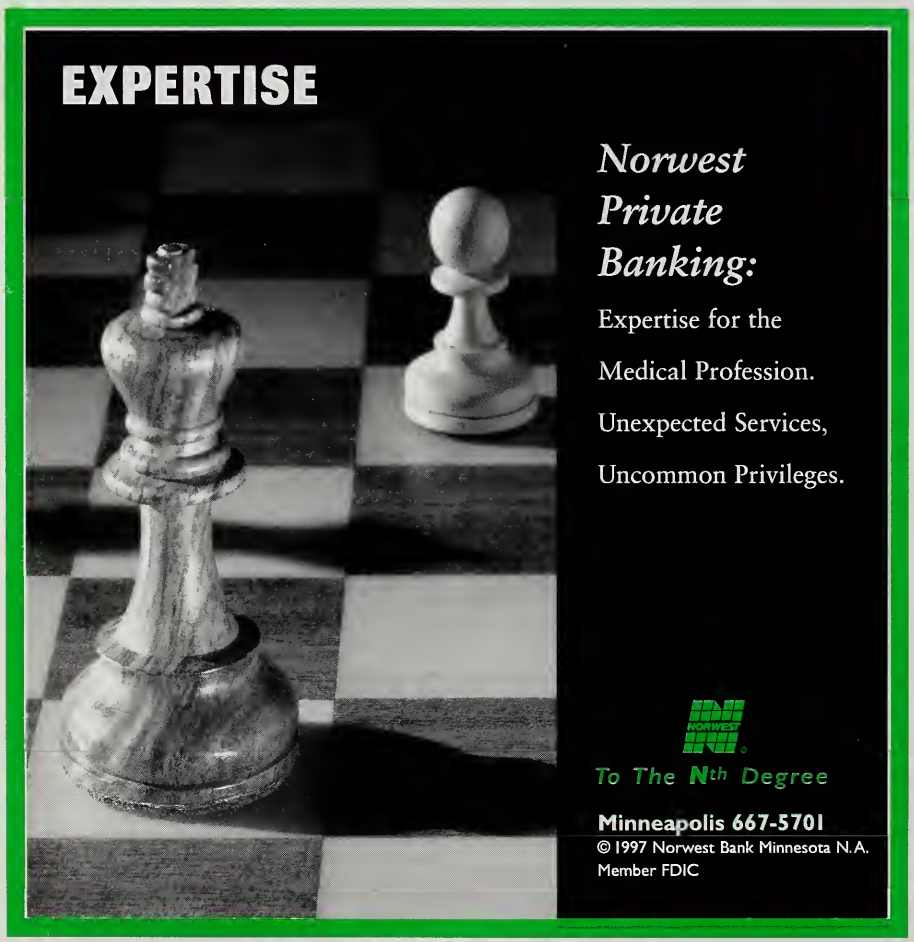
Fifteen of the patients said the health care professionals negatively influenced their level of hope. For example, some said their health care practitioner trivialized their situation and appeared to feel sorry for them or gave them discouraging information in a blunt or disrespectful manner. Patients also lost hope when they received conflicting information, signaling a lack of communication.

The team found that patients who were hopeful were able to handle uncomfortable side effects, continue daily activities, and maintain a functional role within their family. There appears to be a link between hope and cancer survival, but that link has not been proven scientifically, said Post-White, who also is an assistant professor in the School of Nursing and a member of the university's Cancer Center.

Antidepressant Drug Helps People Quit Smoking

The antidepressant drug Zyban appears to be as effective as nicotine products at helping people quit smoking, according to a Mayo Clinic study published in the October 23 *New England Journal of Medicine*. The drug also helped people avoid gaining weight when they quit.

"This is the first non-nicotine product that has been shown to help people stop smoking," said Richard Hurt, M.D., director of the Mayo Nicotine Dependence Center in Rochester and chief investigator for the project. MM



A Calendar of Continuing Medical Education Courses

Provided through the MMA Committee on Accreditation and CME. For assistance with scheduling meetings or for information on future medical meetings and CME courses, please contact the MMA office: 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761; 612/378-1875. For a complete listing of our calendar, visit the MMA home page at www.mnmed.org Information for each entry is arranged by date; name of program; primary sponsor; location; contact person.

DECEMBER 1997

Dec. 5 **Sixth Annual Family Practice Update** Hennepin County Medical Center; Sheraton Airport Hotel, Bloomington, MN. CONTACT: Ann Samways, HCMC Continuing Medical Education, 701 Park Avenue, Mail Code 861-B, Minneapolis, MN 55415-1829; 612/347-2078, toll-free 888/263-4262, or fax 612/904-4210.

JANUARY 1998

Jan. 12-16 **Bone and Soft Tissue Tumors: A Multidisciplinary Approach** Mayo Foundation; Ihilani Resort, Oahu, HI. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Jan. 19-23 **Continuing Challenges in Hematology, Oncology, and Hematopathology** Mayo Medical Laboratories; The Silvertree Hotel, Snowmass, CO. CONTACT: Julie McAdams, 200 First Street SW, Rochester, MN 55905; 507/284-8599.

FEBRUARY 1998

Feb. 26-28 **Mayo Clinic State-of-the-Art Symposium: Arrhythmia Management** Mayo Foundation; Silverado Resort, Napa Valley, CA. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Feb. 27-Mar. 1 **Current Concepts of Erectile Dysfunction: Diagnosis and Treatment** Mayo Foundation; Caribe Royale Resort Suites, Lake Buena Vista, FL. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MARCH 1998

Mar. 8-11 **Neurology in Clinical Practice** Mayo Foundation; Silvertree Hotel and Wildwood Lodge, Snowmass Village, CO. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 9-13 **Selected Topics in Internal Medicine** Mayo Foundation; Maui Prince Resort, Maui, HI. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

Mar. 29-Apr. 3 **Advanced Management Program for Healthcare Executives** University of Minnesota Carlson School of Management and Mayo Clinic; Leighton Auditorium, Mayo Clinic, Rochester, MN. CONTACT: Leanne Andreasen, 200 First Street SW, Rochester, MN 55905; 507/284-3432.

APRIL 1998

Apr. 6-8 **Management Strategies in Complex Congenital Heart Disease** Mayo Foundation; Scottsdale Princess Resort, Scottsdale, AZ. CONTACT: Registrars, Mayo Foundation, Section of Continuing Medical Education, 200 First Street SW, Rochester, MN 55905; 800/323-2688.

MAY 1998

May 5-8 **Fifth International Surgical Pathology Symposium** Mayo Medical Laboratories; Munich, Germany. CONTACT: Kathy Bates, Mayo Clinic, 200 First Street SW, Rochester, MN 55905; E-mail: Kbates@mayo.edu, fax 507/284-4542, fax on demand 800/263-6296 or 507/282-0461.

Infection Control Courses

The following activities have been designed to meet the Minnesota Board of Medical Practice physician licensure requirement for CME credit in the subject of infection control.

Feb. 17-20 **Infectious Diseases** MeritCare Health System; Grouse Mountain Lodge, Whitefish, MT. CONTACT: Cheri Rodenburg, MeritCare Critical Care Services, 720 Fourth Street North, Fargo, ND 58122; 800/437-4010, ext. 6913.

ENDURING MATERIALS

Videotapes: **Bloodborne Pathogens, Antibiotic Update and Resistance, TB Update** Allina Health System. CONTACT: Jim Sargent, 5601 Smetana Drive, PO Box 9310, Minneapolis, MN 55440-9310; 612/992-3897.

Videotapes: **Overview of Tuberculosis, Bloodborne Pathogens, HIV Update** University of Minnesota. CONTACT: Continuing Medical Education, 615 Washington Avenue SE, Suite 107, Minneapolis, MN 55414; 612/626-7600.

MMA-Accredited CME Sponsors

❧ The Minnesota Medical Association is the accrediting agency for Minnesota institutions that regularly sponsor continuing medical education activities for local physicians. ❧ Accreditation gives CME sponsors responsibility for conducting high-quality CME programs and for designating credit for CME activities. ❧ CME programs must comply with the MMA's "Essentials for the Accreditation of Sponsors of Continuing Medical Education" and the ACCME's "Standards for Commercial Support of CME" and "Standards for Enduring Materials." ❧

The MMA Committee on Accreditation and CME has recently granted initial accreditation to Children's Health Care, Minneapolis/St. Paul, and has reaccredited the following CME sponsors:

- ❧ Hennepin County Medical Center, Minneapolis
- ❧ Lakeview Hospital, Stillwater
- ❧ Rice Memorial Hospital, Willmar
- ❧ University Medical Center–Mesabi, Hibbing

For more information on the MMA accreditation program, please call Jane Phillip at the MMA, 612/378-1875 or 800 DIAL-MMA.

"...what Allina did for our careers was great; what they did for our families was amazing."

Allina knows what's important to our physicians. That's why we've created a progressive, not for profit health organization that values your time and talent. We offer desirable call schedules and excellent physician support, allowing you to do the work you love, without abandoning your loved ones. Allina is currently seeking physicians in the following categories: Family Practice, Internal Medicine, Obstetrics, Pediatrics, General Surgery, Emergency Medicine, Urgent Care, Occupational Medicine, Psychiatry, Locum Tenens, and Dermatology.

Our Minnesota/Wisconsin locations have numerous metro and rural opportunities —along with our rewarding career structure, excellent compensation package, and family relocation assistance.

If you love your work, you'll love Allina.

Call our Physicians Services Group
612-992-3093 or 1-800-248-4921
Fax 1-612-992-3669
Allina Health System . Route 80775
5601 Smetana Drive . Minnetonka, MN 55343

ALLINA
HEALTH SYSTEM

HealthPartners®
Institute for Medical Education

CME

CONTINUING MEDICAL EDUCATION
1998 WINTER/SPRING CONFERENCE SCHEDULE

Cardiology Today: CHF: A New Treatment Paradigm,
Speaker: Leslie Miller, M.D., Professor and Director,
Cardiovascular Division, University of Minnesota ..... January 13
Burn Care Today: Accurate Assessment and Appropriate Management ..... February 19-20
Family Medicine ..... March 12-13
Occupational Medicine Update ..... March 20
NIOSH-Approved Spirometry Training ..... March 30-31
OB/Gyn Update ..... April 2-3
ENT Update ..... April 3
Critical Care 1998 ..... April 16-17

In 1996, the HealthPartners Institute for Medical Education (IME) was created to support the ongoing development of excellence in clinical practice through a wide variety of educational services. The Institute has development, coordination and oversight responsibilities for the undergraduate, graduate and continuing education initiatives for health professionals within the various divisions of HealthPartners including Regions Hospital.

FOR FURTHER INFORMATION CONTACT:
Institute for Medical Education
Continuing Education
640 Jackson Street • St. Paul, MN 55101
Phone 612-221-3223 • Fax 612-292-4773

Physician Opportunities and Miscellaneous Listings

Classified rates are $2.00 a word. Minimum monthly charge is $50; with box number $5 additional. Ads will not be accepted by phone.

- Placement of ads must be made six weeks before the date of publication, e.g., December 15 for February ad. Please send ad requests to *Minnesota Medicine,* 3433 Broadway Street NE, Suite 300, Minneapolis, Minnesota 55413-1761.
- The publisher reserves the right to decline or withdraw advertisements. The publisher is not responsible for clerical or typographical errors and is not permitted to divulge the identity of advertisers who have replies sent to box numbers.
- Cancellation of ads must be made by the first of the month preceding month of issue.

Mankato Clinic, Ltd., is seeking additional BC/BE physicians in the following specialties: family practice, general internal medicine, ENT, orthopedic surgery, and pulmonary medicine. The Mankato Clinic is a 70-physician multispecialty group practice in south-central Minnesota with a trade-area population of 250,000+. Guaranteed salary first year, incentive thereafter with full range of benefits and liberal time off. For more information call Dr. Bryon C. McGregor, Medical Director, or Roger Greenwald, Executive Vice President, 507/625-1811, or write PO Box 8674, Mankato, MN 56002-8674. (6/95-R)

Urgent Care Physicians: Friendly, well-established south suburban Minneapolis group seeks physicians part/full time to staff urgent care centers in Bloomington, Burnsville, Edina, Lakeville, and/or Mall of America. Contact Brian Ebeling, M.D., or Patrick Taillefer, Corporate Administrator, at 612/844-1622, or send inquiries to 7801 East Bush Lake Road, Suite 300, Bloomington, MN 55439. (*3/97-R)

Olmsted Medical Center is seeking BC/BE physicians in family medicine, allergy, and emergency medicine, and primary care physicians for occupational medicine to join our 75-physician multispecialty group. Great opportunity for well-trained physicians to join a family-friendly group in a dynamic, progressive practice. In addition to its main office and hospital in Rochester, the Olmsted Medical Center system includes 10 branch office locations in southeastern Minnesota. Excellent salary and benefits including health benefits, malpractice, spending accounts, educational funds, profit sharing, 401K/403B, and relocation assistance. Send CV to Lois Till-Tarara, Olmsted Medical Center, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. (*10/97-R)

Falls Medical Search Seeks Physicians for practice opportunities locally and nationally. To explore new practice options confidentially, send your CV or call Pat Falls, Falls Medical Search, 34 Forest Dale Road, Minneapolis, MN 55410; 612/922-0207 or 800/383-8916. (*5/92-R)

MDsearch assists medical groups and hospitals in their recruiting efforts. For confidential information on opportunities in the Upper Midwest, send CV and/or call collect Mary Jo Cordes, MDsearch, PO Box 21507, St. Paul, MN 55121; 612/454-7291. Fax: 612/454-7277. (2/93-R)

Part-time Neurologist wanted for multidisciplinary office. No call, flexible hours. All inquiries to doctor's private line, 612/889-5973. (2/97-R)

Urgent Care Physicians: We are a growing urgent care practice looking for BC/BE physicians to work full or part time to staff our four clinics. We currently have three locations in the metro area and one location in Mankato and are planning on expanding in 1997. Please contact Cara Auge at 612/593-9818 or 800/511-2820 for more information on joining our growing practice, or send inquiries to 9800 Shelard Parkway, #210, Plymouth, MN 55441. (4/97-R)

Psychiatry—Rural but Near: Seeking the fourth staff psychiatrist for an expanding community psychiatry center. Practice offers highly qualified colleaues, a multidisciplined approach, beautiful facilities, competitive salary, and benefit programs. This growing community, located within one hour of Minneapolis, offers professional options for significant other, walking and biking trails, good school choices, strong economic base, and a safe environment. Contact Verne Meyer, 800/967-2711, fax 320/587-7252, or E-mail: delacore@hutchtel.net. *3-12/97

Emergency Medicine: Olmsted Medical Center is a 75-physician integrated health care system located in Rochester, Minnesota. We are currently searching for a BC/BE primary care physician with emergency medicine experience. ACLS, ATLS, and PALS certifications are required. Our low acuity emergency department has an annual volume of 16,000 patients and advanced technology to provide the highest quality care. Excellent salary and benefits. Malpractice insurance coverage provided. Rochester has been listed as one of the most livable cities in the United States for four years in the *Money* magazine survey. Send CV or call Lois Till-Tarara, Olmsted Medical Center, 1650 Fourth Street SE, Rochester, MN 55904; 507/287-2430. 4-2/98

Minneapolis/St. Paul Internal Medicine Practice: Established, independently owned internal medicine practice for sale. Offers exceptional income and professional opportunity. Inquiries to PO Box 41243, Minneapolis, MN 55441 or call 800/260-0878. 1-12/97

CENTRACare CLINIC

CentraCare Clinic, a multispecialty group of 87 physicians based in St. Cloud, currently has the following openings within our multisite system:

Noninterventional Cardiology	Neurology
Internal Medicine (Little Falls)	Family Practice (Melrose)
Gastroenterology	Infectious Disease

CentraCare Clinic is a progressive, rapidly growing group offering an outstanding lifestyle, compensation and benefits. Our clinics are conveniently located between the Twin Cities and prime Minnesota lake areas.

Contact: John Schnettler
Physician Recruiter
St. Cloud Hospital
1406 Sixth Avenue North
St. Cloud, MN 56303
800-835-6652

Neurologist, Oncologist, Urgent Care, ENT, Dermatologist

There are immediate openings at Brainerd Medical Center for the following specialties: Neurology, Oncology, Urgent Care, Ear, Nose and Throat, and Dermatology.

Brainerd Medical Center, P.A.
- 36-physician independent multi-specialty group
- Located in a primary service area of 40,000 people
- Almost 100% fee-for-service
- Excellent fringe benefits
- Competitive compensation
- Exceptional services available at 162-bed local hospital, St. Joseph's Medical Center

Brainerd, Minnesota
- Surrounded by the premier lakes of Minnesota
- Located in central Minnesota less than 2 1/2 hours from the Twin Cities, Duluth and Fargo
- Large, very progressive school district
- Great community for families

Call collect to Administrator:
- Curt Nielson
  (218) 828-7105
  or (218) 829-4901
  2024 South 6th Street
  Brainerd, MN 56401

BMC

Psychiatrist Needed for thriving outpatient, multispecialty therapy practice. Offices in Rochester and Owatonna, Minnesota. All age groups, high functioning population. Commission based. Call 507/288-8544 or fax 507/288-8545. 1-12/97

Family Physicians: If you think that you can find happiness in a small town in Iowa, please contact me. Jerry Hess, Mercy Family Care Network, 1000 Fourth Street SW, Mason City, Iowa 50401; 515/422-5551, toll-free 888/877-5551, or fax 515/422-6388. 3-2/98

DECEMBER 1997 INDEX TO ADVERTISERS

Acute Care Inc. 19
Affiliated Community Medical Centers 18
Air Force Health Professionals–Ft. Snelling ..... Cover 4
Alexandria Clinic, P.A. 72
Allina Health System 19, 26, 52, 62
Aspen Medical Group 54
Brainerd Medical Center 64
CentraCare Clinic 64
Central Minnesota Group Health Plan 18
Fairview Physician Recruitment & Retention 47
First Call Physicians, Inc 54
Gage Outdoor Expeditions 6
Gillette Children's Specialty Healthcare 5
HealthEast Capitol Medical Laboratory 7
HealthSystem Minnesota 44
Hennepin Medical Society 57
Medical Protective Company ..... Cover 3
Midwest Medical Insurance Co. ..... Cover 2
Minnesota Clinic 30
MMBR 3, 5
Multicare Associates of the Twin Cities 58
Norwest Center 60
Owatonna Clinic 72
Regions Hospital 62
St. Luke's Hospital 19
Staff Care, Inc. 44
Star Tribune 17
Whitesell Medical Locums, Ltd. 58

Volume 80 Index, January-December 1997

A

Achieving Universal Health Care Coverage for Children: The Minnesota Experience. Charles N. Oberg and Deborah Chase, December, 31.

Alcohol Use in Minnesota: Extent and Cost. Doreen Kloehn, Kimberly J. Miner, Don Bishop, and Kathy Daly, May, 26.

Are Medical Savings Accounts an Effective Insurance Alternative? Kimberly Halva, June, 52.

Asp DS: Conducting Truck Drivers' Physical Exams: The High Prevalence of Sleep Apnea, January, 29.

B

Balanced Budget Act and KidCare (The). Janet Silversmith, December, 42.

Baumgarten A: Follow the Money, February, 6.

Baumgarten A: Freedom of Choice ... at a Price, May, 6.

Baumgarten A: Will For-Profit Health Care Give Nonprofits a Run for Their Money? April, 14.

Bell H: Bringing Bioethics Theory to the Bedside, November, 20.

Bell H: Introspection in the House of Medicine, May, 12.

Bell H: Performing Arts Medicine Crescendoes con Spirito, June, 16.

Bladder Stone Causing Renal Failure. C.P. Sundaram, A.M. Houshiar, and P.K. Reddy, September, 25.

Blewett LA, Hofrenning SK: Minnesota: The Land of Nonprofit HMOs, April, 21.

Bringing Bioethics Theory to the Bedside. Howard Bell, November, 20.

Bringing Up Baby: The Nature of Nurturing. Douglas Clement, December, 12.

Bromfield JW: Learning the Language of Fatherhood, December, 10.

Brown M, Parker D, Seeland E, Boyle D, Wahl G: Five Years of Work-Related Injuries and Fatalities in Minnesota: Agriculture—A High-Risk Industry, August, 29.

Brunette DD: A Good Walk Spoiled: Golf's Links to Medicine, June, 25.

Building Assets: A Positive Approach to Adolescent Health. Nancy Leffert, December, 27.

Building Blocks for Healthy Communities (The), March, 6.

Book Reviews

Choices at the End of Life: An Annotated Bibliography. Review of "Forced Exit: The Slippery Slope from Assisted Suicide to Legalized Murder," by Wesley Smith; "Seduced by Death: Doctors, Patients, and the Dutch Cure," by Herbert Hendin; "The Wheel of Life: A Memoir of Living and Dying," by Elizabeth Kubler-Ross; "Denial of the Soul: Spiritual and Medical Perspectives on Euthanasia and Mortality," by M. Scott Peck; "A Midwife through the Dying Process: Stories of Healing and Hard Choices at the End of Life," by Timothy Quill; "Signs of Life: A Memoir of Dying and Discovery," by Tim Brookes; "Dying Well: The Prospect for Growth at the End of Life," by Ira Byock; "Physician-Assisted Suicide," edited by Robert Weir; "Whose Right to Die?" by Ezekiel Emmanuel. Charles R. Meyer, November, 50.

Environmental Thriller (An). Review of "Our Stolen Future," by Theo Colborn, Dianne Dumanoski, and John Peterson Myers. Charles R. Meyer, January, 50.

Logue JN: Managing Disaster. Review of "The Public Health Consequences of Disasters," edited by Eric K. Noji, August, 47.

Managing Disaster. Review of "The Public Health Consequences of Disasters," edited by Eric K. Noji. James N. Logue, August, 47.

Meyer CR: An Environmental Thriller. Review of "Our Stolen Future," by Theo Colborn, Dianne Dumanoski, and John Peterson Myers, January, 50.

Meyer CR: The Power of Raging Waters. Review of "Rising Tide: The Great Mississippi Flood of 1927 and How It Changed America," by John M. Barry, August, 49.

Meyer CR: Residency: A View of the Distant Destination. Review of "Residents: The Perils and Promise of Educating Young Doctors," by David Ewing Duncan, and "Life After Medical School," by Leonard Laster, March, 47.

Meyer CR: A Tale of Two Missionaries. Review of "Brothers in Spirit: The Correspondence of Albert Schweitzer and William Larimer Mellon, Jr.," translated by Jeannette Q. Byers, July, 42.

Mount Sinai Remembered. Review of "Mount Sinai Hospital of Minneapolis, Minnesota: A History," by Fred Lyon. Burton S. Schwartz, September, 43.

Power of Raging Waters (The). Review of "Rising Tide: The Great Mississippi Flood of 1927 and How It Changed America," by John M. Barry. Charles R. Meyer, August, 49.

Residency: A View of the Distant Destination. Review of "Residents: The Perils and Promise of Educating Young Doctors," by David Ewing Duncan, and "Life After Medical School," by Leonard Laster. Charles R. Meyer, March, 47.

Schwartz BS: Mount Sinai Remembered. Review of "Mount Sinai Hospital of Minneapolis, Minnesota: A History," by Fred Lyon, September, 43.

Tale of Two Missionaries (A). Review of "Brothers in Spirit: The Correspondence of Albert Schweitzer and William Larimer Mellon, Jr.," translated by Jeannette Q. Byers. Charles R. Meyer, July, 42.

C

Caplan A: Physician-Assisted Suicide Is Not a Good Option without Decent, Universal Health Care, November, 46.

Caring for Persons with AIDS in Greater Minnesota. Heather Chial and Barbara A. Elliott, February, 43.

Carolan PL, Fernbach KL, Larson SA, and Svenson JC: Impact of the 'Back to Sleep' Campaign on Sudden Infant Death Syndrome in Minnesota, March, 43.

Carter DL, Carter KR: Waging a Noble War against a River, August, 12.

Changing Face of the Veterans Affairs Health Care System (The). Kenneth W. Kizer, February, 24.

Chial H, Elliott BA: Caring for Persons with AIDS in Greater Minnesota, February, 43.

Child Labor: The Impact of Economic Exploitation on the Health and Welfare of Children. David L. Parker, July, 10.

Choices at the End of Life: An Annotated Bibliography. Charles R. Meyer, November, 50.
Clement D: Bringing Up Baby: The Nature of Nurturing, December, 12.
Clement D: Healing the Wounds of War, February, 16.
Clement D: Mission Possible, July, 6.
Close Ties to Parents, School Improve Adolescents' Lives. Michael D. Resnick, December, 24.
Colón K: Tuned In to a New Era in Medicine, September, 6.
Conducting Truck Drivers' Physical Exams: The High Prevalence of Sleep Apnea. Douglas S. Asp, January, 29.
Consumer Rights in the Health Care Marketplace: Minnesota's 1997 Patient Protection Act. Kimberly Halva, September, 30.
Creating a Statewide Immunization Registry: A Tool for Physicians and Public Health. Martin LaVenture, Myrlah Olson, Bill Brand, and Byron Crouse, December, 50.
Crowded Room (A). David S. Hatem, September, 10.

Clinical & Health Affairs

Bladder Stone Causing Renal Failure. C.P. Sundaram, A.M. Houshiar, and P.K. Reddy, September, 25.
Brown M, Parker D, Seeland E, Boyle D, Wahl G: Five Years of Work-Related Injuries and Fatalities in Minnesota: Agriculture—A High-Risk Industry, August, 29.
Brunette DD: A Good Walk Spoiled: Golf's Links to Medicine, June, 25.
Caring for Persons with AIDS in Greater Minnesota. Heather Chial and Barbara A. Elliott, February, 43.
Chial H, Elliott BA. Caring for Persons with AIDS in Greater Minnesota, February, 43.
Domestic Violence: Reality for Some of Your Toughest Patients. Therese Zink, October, 26.
Elliott TE: Pain Control at the End of Life, November, 27.
Five Years of Work-Related Injuries and Fatalities in Minnesota: Agriculture—A High-Risk Industry. Margaret Brown, David Parker, Elizabeth Seeland, Debora Boyle, and George Wahl, August, 29.
Galicich WE, Hall WA, Cho K: The Use of Stereotactic Radiosurgery to Treat Neurological Tumors, September, 18.
Good Walk Spoiled (A): Golf's Links to Medicine. Douglas D. Brunette, June, 25.
Graupman PC, Rockswold GL, Blake D: Thoracoscopic Sympathectomy for Palmar Hyperhidrosis: A Case Report, April, 50.
Heins J, Brust JD: The Physician's Role in Tracking Injuries: The Importance of E-Codes, October, 28.
Incidence of Child Suicide in Minnesota (The). Jon Roesler, December, 45.
Johnson D, Elliott B: Screening for Domestic Violence in a Rural Family Practice, October, 43.
Joint Pain and Weather: A Critical Review of the Literature. Donald C. Quick, March, 25.
Koscheyev VS, Leon GR: Rescue Worker and Population Protection in Large-Scale Contamination Disasters, January, 23.
Pain Control at the End of Life. Thomas E. Elliott, November, 27.
Physician's Role in Tracking Injuries (The): The Importance of E-Codes. Jill Heins and Janny Dwyer Brust, October, 28.
Quick DC: Joint Pain and Weather: A Critical Review of the Literature, March, 25.
Reichert JA, Nagel LW, Solberg NS: Sterilization for Family Planning in a Third World Country, July, 27.
Rescue Worker and Population Protection in Large-Scale Contamination Disasters. Victor S. Koscheyev and Gloria R. Leon, January, 23.
Roesler J: The Incidence of Child Suicide in Minnesota, December, 45.
Rural Enrollment in MinnesotaCare. Barbara P. Yawn and Sarah Krein, April, 42.
Screening for Domestic Violence in a Rural Family Practice. Deane Johnson and Barbara Elliott, October, 43.
Seizures and Spells: Physician Awareness of Minnesota Driving Laws. Kathryn K. Selmo, Donald S. Asp, and David C. Anderson, May, 42.
Selmo KK, Asp DS, Anderson DC: Seizures and Spells: Physician Awareness of Minnesota Driving Laws, May, 42.
Sterilization for Family Planning in a Third World Country. John A. Reichert, Linda Well Nagel, and Norman S. Solberg, July, 27.
Sudoh AC: Tetanus: A Case Report, August, 43.
Sundaram CP, Houshiar AM, Reddy PK: Bladder Stone Causing Renal Failure. September, 25.
Tetanus: A Case Report. Ann C. Sudoh, August, 43.
Thoracoscopic Sympathectomy for Palmar Hyperhidrosis: A Case Report. Patrick C. Graupman, Gaylan L. Rockswold, and David Blake, April, 50.
Use of Stereotactic Radiosurgery to Treat Neurological Tumors (The). Walter E. Galicich, Walter A. Hall, and Kwan Cho, September, 18.
Yawn BP, Krein S: Rural Enrollment in MinnesotaCare, April, 42.
Zink T: Domestic Violence: Reality for Some of Your Toughest Patients. October, 26.

Commentaries

Close Ties to Parents, School Improve Adolescents' Lives. Michael D. Resnick, December, 24.
Haugen PS: Legal Aspects of Pain Relief for the Dying, November, 15.
Hospice: An Alternative to Needless Suffering. Matt Malloy, November, 14.
Legal Aspects of Pain Relief for the Dying. Phebe Saunders Haugen, November, 15.
Malloy M: Hospice: An Alternative to Needless Suffering, November, 14.
Resnick MD: Close Ties to Parents, School Improve Adolescents' Lives. Michael D. Resnick, December, 24.

D

Daube JR: Searching for Cures: The Necessity of Animal Research, September, 27.
Davis ES: Kids at Risk, October, 24.
Diagnostic and Treatment Guide for Domestic Violence. October, 21.
Dieperink ME: Posttraumatic Stress Disorder Among Veterans, February, 29.
Do State Licensing Procedures Discriminate Against Physicians Using Mental Health Services? Steven Miles, January, 42.
Doctor-Patient Bond (The): Covenant or Business Contract? Miriam K. Feldman, September, 12.
Dombrosk S: Physicians Give MMA High Ratings, May, 19.
Domestic Violence: Reality for Some of Your Toughest Patients. Therese Zink, October, 26.
Doyle TJ: Officers, Trustees, Directors Beware! IRS-Imposed 'Intermediate' Sanctions Can Be Severe, April, 53.

E

Easing Performers' Pain. Kim Palmer, June, 6.
Elliott TE: Pain Control at the End of Life, November, 27.
Embracing Change. Kim Palmer, February, 8.
Environmental Thriller (An). Review of "Our Stolen Future," by Theo Colborn, Dianne Dumanoski, and John Peterson Myers. Charles R. Meyer, January, 50.

Editorials

Daube JR: Searching for Cures: The Necessity of Animal Research, September, 27.
Do State Licensing Procedures Discriminate Against Physicians Using Mental Health Services? Steven Miles, January, 42.
McCollum D: When Symptoms Defy Diagnosis, October, 10.
Miles S: Do State Licensing Procedures Discriminate Against Physicians Using Mental Health Services? January, 42.
Searching for Cures: The Necessity of Animal Research. Jasper R. Daube, September, 27.
When Symptoms Defy Diagnosis. David McCollum, October, 10.

Editor's Note

Meyer, Charles R:
Being There, December, 2.
Call to Action (A), July, 3.
Diagnosing Environmental Disasters, January, 2.
Epidemic Sanctioned by Society (An), October, 2.
Ministering to Dying Patients, November, 2.
New Generation of MDs (A), March, 2.
No Clubs in this Closet, June, 2.
Professional Privilege, September, 2.
Professional Solidarity, May, 2.
Public Health: Aseptic, Not Boring, August, 2.
Should We Take the For-Profit Plunge? April, 2.
War Is Our Worst Chronic Disease, February, 2.

F

Feldman MK: The Doctor-Patient Bond: Covenant or Business Contract? September, 12.
Feldman MK: Going to Extremes, January, 8.
Feldman MK: International Medicine: Outside the Comfort Zone, July, 14.
Feldman MK: Move Over, Medicine! Today's Doctors Say There's More to Life, March, 12.
Five Years of Work-Related Injuries and Fatalities in Minnesota: Agriculture—A High-Risk Industry. Margaret Brown, David Parker, Elizabeth Seeland, Debora Boyle, and George Wahl, August, 29.
Floodwaters Bring Physicians to the Front. Karen M. Stensrud, August, 14.
Follow the Money. Allan Baumgarten, February, 6.
For-Profit and Not-for-Profit Health Care Organizations: An Annotated Bibliography. Robert Koepp and Steven H. Miles, April, 27.
Franklin PL: Physician-Assisted Suicide: The U.S. Supreme Court Weighs In, November, 45.
Frederick LM, Farney AC: Legal Issues and Remedies for Victims of Domestic Violence, October, 47.
Freedom of Choice ... at a Price. Allan Baumgarten, May, 6.

Face to Face

Cline, Michael, and McLane, Rebecca
A Promising Partnership. Carolyn Griffith, October, 6.
Hafner, Rebecca
Lessons from the Monastery. Anne Welsbacher, November, 6.
Holtan, Neal
Split Shift. Jeremiah Christopher Whitten, August, 8.
Koscheyev, Victor
Going to Extremes. Mirian K. Feldman, January, 8.
McGuire, William W.
Uniting Business and Medicine. Charles R. Meyer, April, 8.
Petzel, Robert
Embracing Change. Kim Palmer, February, 8.
Propes, Beverly
The Building Blocks for Healthy Communities, March, 6.
Sanders, Paul
MMA's Chief Doctor. Lorrie Holmgren, May, 8.
Speier, Jennine
Easing Performers' Pain. Kim Palmer. June, 6.
Trockman, Rachel
Seeing the Child Behind the Diagnosis. Jeremiah C. Whitten. December, 8.
Vitalis, Susan
Mission Possible. Douglas Clement, July, 6.
Wilson, Kent S.
Tuned In to a New Era in Medicine. Katie Colón, September, 6.

G

Galicich WE, Hall WA, Cho K: The Use of Stereotactic Radiosurgery to Treat Neurological Tumors, September, 18.
Geographic Disparities in Medicare Reimbursement. Janet Silversmith, June, 45.
Gillette Children's Specialty Healthcare: For Kids' Sake. Jeremiah Christopher Whitten, May, 22
Going to Extremes. Miriam K. Feldman, January, 8.
Good Walk Spoiled (A): Golf's Links to Medicine. Douglas D. Brunette, June, 25.
Graupman PC, Rockswold GL, Blake D: Thoracoscopic Sympathectomy for Palmar Hyperhidrosis: A Case Report, April, 50.
Griffith C: A Promising Partnership, October, 6.

H

Halva K: Are Medical Savings Accounts an Effective Insurance Alternative? June, 52.
Halva K: Consumer Rights in the Health Care Marketplace: Minnesota's 1997 Patient Protection Act, September, 30.
Halva K: Minor Consent to Treatment, December, 53.
Hatem DS: A Crowded Room, September, 10.
Haugen PS: Legal Aspects of Pain Relief for the Dying, November, 15.
Healing the Wounds of War. Douglas Clement, February, 12.
Heartening Exchange (A). Jeremiah Christopher Whitten, July, 20.
Heins J, Brust JD: The Physician's Role in Tracking Injuries: The Importance of E-Codes, October, 28.
Help for Men Who Hurt: Treating the Batterer. Kim Palmer, October, 14.
Holmgren L: MMA's Chief Doctor, May, 8.

Hospice: An Alternative to Needless Suffering. Matt Malloy, November, 14.
Hospice Care for Terminally Ill Hmong Patients: A Good Cultural Fit? Dorothy E. Vawter and Barbara Babbitt, November, 42.

HealthScene Minnesota

Baumgarten A: Follow the Money, February, 6.
Baumgarten A: Freedom of Choice ... at a Price, May, 6.
Follow the Money. Allan Baumgarten, February, 6.
Freedom of Choice ... at a Price. Allan Baumgarten, May, 6.

I

Impact of the Americans with Disabilities Act on Medical Licensing and Credentialing (The). Margo S. Struthers and Melissa Raphan, January, 47.
Impact of the 'Back to Sleep' Campaign on Sudden Infant Death Syndrome in Minnesota. Patrick L. Carolan, Kathleen L. Fernbach, Sharyn A. Larson, and Junie C. Svenson, March, 43.
Incidence of Child Suicide in Minnesota (The). Jon Roesler, December, 45.
Informed Consent: Still a Physician's Duty. Shirley Qual, February, 51.
International Medicine: Outside the Comfort Zone. Miriam K. Feldman, July, 14.
Introspection in the House of Medicine. Howard Bell, May, 12.
Is Direct Contracting the Business of Insurance? Margo S. Struthers and Paul D. Anderson, May, 49

In Memoriam

A Tribute to Cassius Marcellus Clay Ellis III. John S. Najarian, September, 45.
Najarian JS: A Tribute to Cassius Marcellus Clay Ellis III, September, 45.

J

Jacobson M: A Letter from Tanzania, July, 8.
Joint Pain and Weather: A Critical Review of the Literature. Donald C. Quick, March, 25.
Johnson D, Elliott B: Screening for Domestic Violence in a Rural Family Practice, October, 43.
Just Over the Horizon. Andrea Matthews, November, 10.

K

Kids at Risk. Ericka Sojourner Davis, October, 24.
Kizer KW: The Changing Face of the Veterans Affairs Health Care System, February, 24.
Kloehn D, Miner KJ, Bishop D, Daly K: Alcohol Use in Minnesota: Extent and Cost, May, 26.
Koepp R, Miles SH: For-Profit and Not-for-Profit Health Care Organizations: An Annotated Bibliography, April, 27.
Koscheyev VS, Leon GR: Rescue Worker and Population Protection in Large-Scale Contamination Disasters, January, 23.
Kralewski JE: Untangling the Cost of Family Practice Residency Training, March, 19.
KSTP-TV Investigative Report Sells Fear, Not Facts. Charles R. Meyer, August, 6.

L

LaVenture M, Olson M, Brand B, Crouse B: Creating a Statewide Immunization Registry: A Tool for Physicians and Public Health, December, 50.
Learning the Language of Fatherhood. J.W. Bromfield, December, 10.
Leffert N: Building Assets: A Positive Approach to Adolescent Health, December, 27.
Legal Aspects of Pain Relief for the Dying. Phebe Saunders Haugen, November, 15.
Legal Issues and Remedies for Victims of Domestic Violence. Loretta M. Frederick and Andrea C. Farney, October, 47.
Leitheiser AT, Rippke M, Sheehan M, Korlath J, Ferguson B: Public Health Response to the 1997 Minnesota Flood: Lessons Learned, August, 25.
Lessons from the Monastery. Anne Welsbacher, November, 6.
Letter from Tanzania (A). Mark Jacobson, July, 8.
Letter to Lara (A). Robert R. Raszkowski, March, 10.
Logue JN: Managing Disaster. Review of "The Public Health Consequences of Disasters," edited by Eric K. Noji, August, 47.
Lupo VR: Screening Pregnant Women for HIV, February, 48.

Letters to the Editor

Act of Courage (An). Judith F. Kashtan, April, 6.
Barnett M: Thanks for Addressing Domestic Abuse, December, 7.
BMP Approach Deters Mental Illness Treatment. Name Withheld, April, 6.
Call for GPO Members (A). Virginia Caspersen, April, 7.
Caspersen V: A Call for GOP Members, April, 7.
Direct Access to Ob/Gyns Is About Women, Not Turf. Janette H. Strathy, July, 4.
Dombrosk S: Thank You for Sharing Comments on the MMA's Web Site, January, 6.
Gillispie MA: Public Health/Flood Issue Timely and Useful, December, 6.
Government, Not War, Is Our Worst Disease. Ted Papermaster, April, 6.
Great Issue on Spirituality. Pat Zook, April, 7.
Handler S: 'Our Stolen Future' Is a Rook, April, 6.
Heartfelt Thanks (A). Katie Regnier, December, 6.
Just Part of the Domestic Abuse Picture. Mark T. Sprangers, December, 7.
Kashtan JF: An Act of Courage, April, 6.
'Our Stolen Future' Is a Rook. Seymour Handler, April, 6.
Papermaster T: Government, Not War, Is Our Worst Disease, April, 6.
Public Health/Flood Issue Timely and Useful. Mary Alice Gillispie, December, 6.
Regnier K: A Heartfelt Thanks, December, 6.
Sprangers MT: Just Part of the Domestic Abuse Picture, December, 7.
Strathy JH: Direct Access to Ob/Gyns Is About Women, Not Turf, July, 4.
Thanks for Addressing Domestic Abuse. Maxine Barnett, December, 7.
Thank You for Sharing Comments on the MMA's Web Site. Steve Dombrosk, January, 6.
Tips for Improving the MMA's Home Page. Pat Zook, January, 6.
Zook P: Great Issue on Spirituality, April, 7.
Zook P: Tips for Improving the MMA's Home Page, January, 6.

M

Maas S: Physicians Prescribe Parent Education, December, 20.
Malloy M: Hospice: An Alternative to Needless Suffering, November, 14.
Managing Disaster. Review of 'The Public Health Consequences of Disasters," edited by Eric K. Noji. James N. Logue, August, 47.
Matthews A: Just Over the Horizon, November, 10.
McCollum D: When Symptoms Defy Diagnosis, October, 10.
Meyer CR: Choices at the End of Life: An Annotated Bibliography, November, 50.
Meyer CR: An Environmental Thriller. Review of "Our Stolen Future," by Theo Colborn, Dianne Dumanoski, and John Peterson Myers, January, 50.
Meyer CR: KSTP-TV Investigative Report Sells Fear, Not Facts, August, 6.
Meyer CR: The Power of Raging Waters. Review of "Rising Tide: The Great Mississippi Flood of 1927 and How It Changed America," by John M. Barry, August, 49.
Meyer CR: Residency: A View of the Distant Destination. Review of "Residents: The Perils and Promise of Educating Young Doctors," by David Ewing Duncan and "Life After Medical School," by Leonard Laster, March, 47.
Meyer CR: A Tale of Two Missionaries. Review of "Brothers in Spirit: The Correspondence of Albert Schweitzer and William Larimer Mellon, Jr.," translated by Jeannette Q. Byers, July, 42.
Meyer CR: Uniting Business and Medicine, April, 8.
Miles S: Do State Licensing Procedures Discriminate Against Physicians Using Mental Health Services? January, 42.
Minnesota: The Land of Nonprofit HMOs. Lynn A. Blewett and Stella K. Hofrenning, April, 21.
Minor Consent to Treatment. Kimberly Halva, December, 53.
Mission Possible. Douglas Clement, July, 6.
MMA's Chief Doctor. Lorrie Holmgren, May, 8.
Moore MP: Unraveling the Mysteries of Environmental Medicine, January, 12.
Mount Sinai Remembered. Review of "Mount Sinai Hospital of Minneapolis, Minnesota: A History," by Fred Lyon. Burton S. Schwartz, September, 43.
Move Over, Medicine! Today's Doctors Say There's More to Life. Miriam K. Feldman, March, 12.
Murray MJ. The Reserve Physician, February, 12.

Media Watch

KSTP-TV Investigative Report Sells Fear, Not Facts. Charles R. Meyer, August, 6.
Meyer CR: KSTP-TV Investigative Report Sells Fear, Not Facts, August, 6.

Medicine Law & Policy

Are Medical Savings Accounts an Effective Insurance Alternative? Kimberly Halva, June, 52.
Consumer Rights in the Health Care Marketplace: Minnesota's 1997 Patient Protection Act. Kimberly Halva, September, 30.
Doyle TJ: Officers, Trustees, Directors Beware! IRS-Imposed 'Intermediate' Sanctions Can Be Severe, April, 53.
Franklin PL: Physician-Assisted Suicide: The U.S. Supreme Court Weighs In, November, 45.
Frederick LM, Farney AC: Legal Issues and Remedies for Victims of Domestic Violence, October, 47.
Halva K: Are Medical Savings Accounts an Effective Insurance Alternative? June, 52.
Halva K: Consumer Rights in the Health Care Marketplace: Minnesota's 1997 Patient Protection Act, September, 30.
Halva K: Minor Consent to Treatment, December, 53.
Impact of the Americans with Disabilities Act on Medical Licensing and Credentialing (The). Margo S. Struthers and Melissa Raphan, January, 47.
Informed Consent: Still a Physician's Duty. Shirley Qual, February, 51.
Is Direct Contracting the Business of Insurance? Margo S. Struthers and Paul D. Anderson, May, 49.
Legal Issues and Remedies for Victims of Domestic Violence. Loretta M. Frederick and Andrea C. Farney, October, 47.
Minor Consent to Treatment. Kimberly Halva, December, 53.
Officers, Trustees, Directors Beware! IRS-Imposed 'Intermediate' Sanctions Can Be Severe. Thomas J. Doyle, April, 53.
Physician-Assisted Suicide: The U.S. Supreme Court Weighs In. Patricia L. Franklin, November, 45.
Qual S: Informed Consent: Still a Physician's Duty, February, 51.
Struthers MS, Anderson PD: Is Direct Contracting the Business of Insurance? May, 49.
Struthers MS, Raphan M: The Impact of the Americans with Disabilities Act on Medical Licensing and Credentialing, January, 47.

Minnesota Medical Association

Are Medical Savings Accounts an Effective Insurance Alternative? Kimberly Halva, June, 52.
Balanced Budget Act and KidCare (The). Janet Silversmith, December, 42.
Consumer Rights in the Health Care Marketplace: Minnesota's 1997 Patient Protection Act. Kimberly Halva, September, 30.
Franklin PL: Physician-Assisted Suicide: The U.S. Supreme Court Weighs In, November, 45.
Geographic Disparities in Medicare Reimbursement. Janet Silversmith, June, 45.
Halva K: Are Medical Savings Accounts an Effective Insurance Alternative? June, 52.
Halva K: Consumer Rights in the Health Care Marketplace: Minnesota's 1997 Patient Protection Act, September, 30.
Halva K: Minor Consent to Treatment. December, 53.
Holmgren L: MMA's Chief Doctor, May, 8.
Minor Consent to Treatment. Kimberly Halva, December, 53.
MMA's Chief Doctor. Lorrie Holmgren, May, 8.
Physician-Assisted Suicide: The U.S. Supreme Court Weighs In. Patricia L. Franklin, November, 45.
Silversmith J: Geographic Disparities in Medicare Reimbursement, June, 45.
Silversmith J: The Balanced Budget Act and KidCare, December, 42.
Use and Care of Animals in Research and Teaching: MMA Policy Statement, September, 28.

N, O

Najarian JS: A Tribute to Cassius Marcellus Clay Ellis III, September, 45.
Oberg CN, Chase D: Achieving Universal Health Care Coverage for Children: The Minnesota Experience, December, 31.
Officers, Trustees, Directors Beware! IRS-Imposed 'Intermediate' Sanctions Can Be Severe. Thomas J. Doyle, April, 53.

P

Pain Control at the End of Life. Thomas E. Elliott, November, 27.
Palmer K: Easing Performers' Pain, June, 6.
Palmer K: Embracing Change, February, 8.
Palmer K: Help for Men Who Hurt: Treating the Batterer, October, 14.
Parker DL: Child Labor: The Impact of Economic Exploitation on the Health and Welfare of Children, July, 10.
Partnership for Public Health (A). August, 20.
Performing Arts Medicine Crescendoes con Spirito. Howard Bell, June, 16.
Physician-Assisted Suicide: The U.S. Supreme Court Weighs In. Patricia L. Franklin, November, 45.
Physicians Give MMA High Ratings. Stephen Dombrosk, May, 19.
Physicians Prescribe Parent Education. Susan Maas, December, 20.
Physician's Role in Tracking Injuries (The): The Importance of E-Codes. Jill Heins and Janny Dwyer Brust, October, 28.
Posttraumatic Stress Disorder Among Veterans. Michael E. Dieperink, February, 29.
Power of Raging Waters (The). Review of "Rising Tide: The Great Mississippi Flood of 1927 and How It Changed America," by John M. Barry. Charles R. Meyer, August, 49.
Promising Partnership (A). Carolyn Griffith, October, 6.
Public Health Response to the 1997 Minnesota Flood: Lessons Learned. Agnes T. Leitheiser, Mary Rippke, Mary Sheehan, Jack Korlath, and Buddy Ferguson, August, 25.

Pearls & Pointers

Obtaining Venous Access in Newborns. Richard C. Lussky, March, 3.
Lussky RC: Obtaining Venous Access in Newborns, March, 3.

Perspectives

Bromfield JW: Learning the Language of Fatherhood, December, 10.
Carter KR, Carter DL: Waging a Noble War against a River, August, 12.
Crowded Room (A). David S. Hatem, September, 10.
Davis ES: Kids at Risk, October, 24.
Hatem DS: A Crowded Room, September, 10.
Jacobson M: A Letter from Tanzania, July, 8.
Just Over the Horizon. Andrea Matthews, November, 10.
Kids at Risk. Ericka Sojourner Davis, October, 24.
Learning the Language of Fatherhood. J.W. Bromfield, December, 10.
Letter from Tanzania (A). Mark Jacobson, July, 8.
Letter to Lara (A). Robert R. Raszkowski, March, 10.
Matthews A: Just Over the Horizon, November, 10.
Murray MJ: The Reserve Physician, February, 12.
Raszkowski RR: A Letter to Lara, March, 10.
Reserve Physician (The). Michael J. Murray, February, 12.
Road Best Traveled (The). Robert L. Veninga, June, 10.
Townsend C: Urban Medicine, April, 12.
Urban Medicine. Colleen Townsend, April, 12.
Veninga RL. The Road Best Traveled, June, 10.
Waging a Noble War against a River. Kenneth R. Carter and Darrell L. Carter, August, 12.

Public Health Reports

Alcohol Use in Minnesota: Extent and Cost. Doreen Kloehn, Kimberly J. Miner, Don Bishop, and Kathy Daly, May, 26.
Carolan PL, Fernbach KL, Larson SA, Svenson JC: Impact of the 'Back to Sleep' Campaign on Sudden Infant Death Syndrome in Minnesota, March, 43.
Creating a Statewide Immunization Registry: A Tool for Physicians and Public Health. Martin LaVenture, Myrlah Olson, Bill Brand, and Byron Crouse, December, 50.
Impact of the 'Back to Sleep' Campaign on Sudden Infant Death Syndrome in Minnesota. Patrick L. Carolan, Kathleen L. Fernbach, Sharyn A. Larson, and Junie C. Svenson, March, 43.
Kloehn D, Miner KJ, Bishop D, Daly K: Alcohol Use in Minnesota: Extent and Cost. May, 26.
LaVenture M, Olson M, Brand B, Crouse B: Creating a Statewide Immunization Registry: A Tool for Physicians and Public Health, December, 50.
Leitheiser AT, Rippke M, Sheehan M, Korlath J, Ferguson B: Public Health Response to the 1997 Minnesota Flood: Lessons Learned, August, 25.
Lupo VR: Screening Pregnant Women for HIV, February, 48.
Public Health Response to the 1997 Minnesota Flood: Lessons Learned. Agnes T. Leitheiser, Mary Rippke, Mary Sheehan, Jack Korlath, and Buddy Ferguson, August, 25.
Routine Screening During Pregnancy: The New Minnesota Pregnancy Risk Assessment Form. Pamela Weiss and Peter M. Mark, December, 48.
Screening Pregnant Women for HIV. Virginia R. Lupo, February, 48.
Shaken Baby Syndrome: Diagnosis and Prevention. Jane Swenson and Carolyn Levitt, June, 41.
Swenson J, Levitt C: Shaken Baby Syndrome: Diagnosis and Prevention, June, 41.
Weiss P, Mark PM: Routine Screening During Pregnancy: The New Minnesota Pregnancy Risk Assessment Form, December, 48.

Q

Qual S: Informed Consent: Still a Physician's Duty, February, 51.
Quick DC: Joint Pain and Weather: A Critical Review of the Literature, March, 25.

R

Raszkowski RR: A Letter to Lara, March, 10.
Reichert JA, Nagel LW, Solberg NS: Sterilization for Family Planning in a Third World Country, July, 27.
Rescue Worker and Population Protection in Large-Scale Contamination Disasters. Victor S. Koscheyev and Gloria R. Leon, January, 23.
Reserve Physician (The). Michael J. Murray, February, 12.

Residency: A View of the Distant Destination. Review of "Residents: The Perils and Promise of Educating Young Doctors," by David Ewing Duncan, and "Life After Medical School," by Leonard Laster. Charles R. Meyer, March, 47.
Resnick MD: Close Ties to Parents, School Improve Adolescents' Lives, December, 24.
Road Best Traveled (The). Robert L. Veninga, June, 10.
Roesler J: The Incidence of Child Suicide in Minnesota, December, 45.
Routine Screening During Pregnancy: The New Minnesota Pregnancy Risk Assessment Form. Pamela Weiss and Peter M. Mark, December, 48.
Rural Enrollment in MinnesotaCare. Barbara P. Yawn and Sarah Krein, April, 42.

S

Schwartz BS: Mount Sinai Remembered. Review of "Mount Sinai Hospital of Minneapolis, Minnesota: A History," by Fred Lyon, September, 43.
Screening for Domestic Violence in a Rural Family Practice. Deane Johnson and Barbara Elliott, October, 43.
Screening Pregnant Women for HIV. Virginia R. Lupo, February, 48.
Searching for Cures: The Necessity of Animal Research. Jasper R. Daube, September, 27.
Seeing the Child Behind the Diagnosis. Jeremiah C. Whitten, December, 8.
Seizures and Spells: Physician Awareness of Minnesota Driving Laws. Kathryn K. Selmo, Donald S. Asp, and David C. Anderson, May, 42.
Selmo KK, Asp DS, Anderson DC: Seizures and Spells: Physician Awareness of Minnesota Driving Laws, May, 42.
Shaken Baby Syndrome: Diagnosis and Prevention. Jane Swenson and Carolyn Levitt, June, 41.
Silversmith J: Geographic Disparities in Medicare Reimbursement, June, 45.
Silversmith J: The Balanced Budget Act and KidCare, December, 42.
Split Shift. Jeremiah Christopher Whitten, August, 8.
Stensrud KM: Floodwaters Bring Physicians to the Front, August, 14.
Sterilization for Family Planning in a Third World Country: John A. Reichert, Linda Well Nagel, and Norman S. Solberg, July, 27.
Struthers MS, Anderson PD: Is Direct Contracting the Business of Insurance? May, 49.
Struthers MS, Raphan M: The Impact of the Americans with Disabilities Act on Medical Licensing and Credentialing, January, 47.
Sudoh AC: Tetanus: A Case Report, August, 43.
Sundaram CP, Houshiar AM, Reddy PK: Bladder Stone Causing Renal Failure. September, 25.
Swenson J, Levitt C: Shaken Baby Syndrome: Diagnosis and Prevention, June, 41.

Special Reports

Achieving Universal Health Care Coverage for Children: The Minnesota Experience. Charles N. Oberg and Deborah Chase, December, 31.
Asp DS: Conducting Truck Drivers' Physical Exams: The High Prevalence of Sleep Apnea, January, 29.
Blewett LA, Hofrenning SK: Minnesota: The Land of Nonprofit HMOs, April, 21.
Building Assets: A Positive Approach to Adolescent Health. Nancy Leffert, December, 27.
Changing Face of the Veterans Affairs Health Care System (The). Kenneth W. Kizer, February, 24.
Child Labor: The Impact of Economic Exploitation on the Health and Welfare of Children. David L. Parker, July, 10.
Conducting Truck Drivers' Physical Exams: The High Prevalence of Sleep Apnea. Douglas S. Asp, January, 29.
Dieperink ME: Posttraumatic Stress Disorder Among Veterans, February, 29.
Dombrosk S: Physicians Give MMA High Ratings, May, 19.
For-Profit and Not-for-Profit Health Care Organizations: An Annotated Bibliography. Robert Koepp and Steven H. Miles, April, 27.
Geographic Disparities in Medicare Reimbursement. Janet Silversmith, June, 45.
Hospice Care for Terminally Ill Hmong Patients: A Good Cultural Fit? Dorothy E. Vawter and Barbara Babbitt, November, 42.
Kizer KW: The Changing Face of the Veterans Affairs Health Care System, February, 24.
Koepp R, Miles SH: For-Profit and Not-for-Profit Health Care Organizations: An Annotated Bibliography, April, 27.
Kralewski JE: Untangling the Cost of Family Practice Residency Training, March, 19.
Leffert N: Building Assets: A Positive Approach to Adolescent Health, December, 27.
Minnesota: The Land of Nonprofit HMOs. Lynn A. Blewett and Stella K. Hofrenning, April, 21.
Oberg CN, Chase D: Achieving Universal Health Care Coverage for Children: The Minnesota Experience, December, 31.
Parker DL: Child Labor: The Impact of Economic Exploitation on the Health and Welfare of Children, July, 10.
Physicians Give MMA High Ratings. Stephen Dombrosk, May, 19.
Posttraumatic Stress Disorder Among Veterans. Michael E. Dieperink, February, 29.
Silversmith J: Geographic Disparities in Medicare Reimbursement, June, 45.
Untangling the Cost of Family Practice Residency Training. John E. Kralewski, March, 19.
Vawter DE, Babbitt B: Hospice Care for Terminally Ill Hmong Patients: A Good Cultural Fit? November, 42.

T

Tale of Two Missionaries (A): Review of "Brothers in Spirit: The Correspondence of Albert Schweitzer and William Larimer Mellon, Jr.," translated by Jeannette Q. Byers. Charles R. Meyer, July, 42.
Tetanus: A Case Report. Ann C. Sudoh, August, 43.
Thoracoscopic Sympathectomy for Palmar Hyperhidrosis: A Case Report. Patrick C. Graupman, Gaylan L. Rockswold, and David Blake, April, 50.
Townsend C: Urban Medicine, April, 12.
Tribute to Cassius Marcellus Clay Ellis III (A). John S. Najarian, September, 45.
Tuned In to a New Era in Medicine. Katie Colón, September, 6.

U

Uniting Business and Medicine. Charles R. Meyer, April, 8.
Unraveling the Mysteries of Environmental Medicine. Michael P. Moore, January, 12.
Untangling the Cost of Family Practice Residency Training. John E. Kralewski, March, 19.
Urban Medicine. Colleen Townsend, April, 12.
Use and Care of Animals in Research and Teaching: MMA Policy Statement, September, 28.
Use of Stereotactic Radiosurgery to Treat Neurological Tumors (The). Walter E. Galicich, Walter A. Hall, and Kwan Cho, September, 18.

V

Vawter DE, Babbitt B: Hospice Care for Terminally Ill Hmong Patients: A Good Cultural Fit? November, 42.
Veninga RL: The Road Best Traveled, June, 10.

W

Waging a Noble War against a River. Kenneth R. Carter and Darrell L. Carter, August, 12.
Weiss P, Mark PM: Routine Screening During Pregnancy: The New Minnesota Pregnancy Risk Assessment Form, December, 48.
Welsbacher A: Lessons from the Monastery, November, 6.
When Symptoms Defy Diagnosis. David McCollum, October, 10.
Whitten JC: Gillette Children's Specialty Healthcare: For Kids' Sake, May, 22.
Whitten JC: A Heartening Exchange, July, 20.
Whitten JC: Seeing the Child Behind the Diagnosis, December, 8.
Whitten JC: Split Shift, August, 8.
Will For-Profit Health Care Give Nonprofits a Run for Their Money? Allan Baumgarten, April, 14.

Y, Z

Yawn BP, Krein S: Rural Enrollment in MinnesotaCare, April, 42.
Zink T: Domestic Violence: Reality for Some of Your Toughest Patients, October, 26.



ALEXANDRIA CLINIC, P.A.

The Alexandria Clinic, P.A., is a 32-physician multi-specialty group currently recruiting additional physicians in the following specialties:

- DERMATOLOGY
- ENT
- INTERNAL MEDICINE

First-year salary guarantee with production bonus, second-year partnership. Excellent contract benefits.

If interested in joining a young, growing organization located in beautiful lakes area community, please contact:

Administrator
Alexandria Clinic, P.A.
610 Fillmore Street
Alexandria, MN 56308
320•763•5123

A place to practice, a place to live

Mpls St Paul magazine ranks Owatonna one of Minnesota's eight great small towns. We enjoy:

- Proximity to the Twin Cities
- Excellent schools
- Pleasant neighborhoods
- Recreational opportunities

A growing group practice of 28 physicians, we want to expand our physician team in:

- Family practice
- Internal medicine
- Obstetrics and gynecology

For more information contact David Berg, Owatonna Clinic administrator, at 507-455-4441.

Owatonna Clinic
Mayo Health System

Health Sciences & Human Services Library
University of Maryland
Baltimore

NOT TO CIRCULATE

Health Sciences & Human Services Library
University of Maryland
Baltimore

NOT TO CIRCULATE

Wert
Bookbinding
Grantville, PA
APR-JUNE 1998